Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 11:47 PM 2007 **JOSEPH** GLENN SNYDER TR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner baltimore Jultimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**2** M 2□ F Days Hours Min. 219-20-6553 March 19,1923 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: if item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3515 Melody Lane U.S.A 21244 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M2 Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 ò Q Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City Police 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi Joseph Glenn Snyder Sr. Katherine Proctor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33042 Pages 1 and 2 s Health a Joseph Glenn Snyder III (Son) 17183 Green Turtle Lane West Summerland Key, Florida e of Disposition (Name of Date 20c. Location - City or Town, State Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 07-20-07 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Avenue, Baltimore, Maryland 21230 Signature of Fugeral Service Licenses ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Subclura **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to limite liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans 3 Ectopic pregnate (Reported By MEDIC)
5 Other (specify) Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has performe trai or Attending Physician: The safter death.

rai Director: After this certificate led in by the funeral director, pa 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ res 2 ☐ No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Place of injury - At home, farm, street, factory, office building, etc. (Specify) Fell down thight of stars 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Bultimore, MD 4 Homicide 1706 Hill drive within 24 hours a To the Funeral C 71244 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16,2007 Å

Registrar

State

30. Name and a set ss of person who come ted cause

2

SYNUANUS 31. Date filed (Month, Day, Year)

KNOWN

SINAL

HOSPITAL

OF BALTIMORS

of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar	ite of Maryland		riment of Y tificate of I		/lental Hygie яед.	C. C	23502
	Physici /Medi		Decedent's Name (First, Middle, Last)     DORIS			SCHWAR	TZ		Day Year 18 2007	3. Time of Death 4:40 A M
	Examir		4a. Facility Name (If not institution, give street a STELLA MARIS HOSP)			4b. City, Town, or	Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye) 04/10/192	ar) Cou	nplace (State or Foreign untry) NY
	aryland show	٥٢	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M a or 28a-f be notifie	Director	MD BALTIMORE  10e. Street and Number		COCKE	YSVILLE 10f. Zip Code		10g.	Citizen of What Cou	untry?
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	1 Never Married 2 Married 1.	LL #F as Decedent Ever in U.S med Forces? JYes 250 No Yes, Give X ar or Dates:		□Yes 2M2 No	ispanic Origin? (Span, Mexican, Puerto		14. Race - Amer Black, White	ican Indian, e, etc. WHITE
	Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental Hyglene. It is marked other than "natural", or traumatic event, the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)	oleted) ollege (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done o OO NOT use retired MAKER	ation during most of work d)	ing 16b	OWN HOI	·
. M.	/land //	To Be C	17. Father's Name ( <i>First, Middle, Last</i> ) HENRY		WEN	DORF	18. Mother's Nam	e (First, Middle, Maid	,	BELOVE
( )	h, Mary and 2 sho ealth and I n 27 is me her traums	ľ		SBAND	10036	HILLGRE	EN CIRCLE		SVILLE, M	D 21030
4:4	<b>Saltimore,</b> permit. Pages 1 a Department of Hee mportant: If them nny injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	ol from Ctato C6	TOP S		ORP. 07/1		TOWSON, MI	D
i	Balti permit. Departr Importa any inju		21. Signature of Funeral Service License	hl			STERSTOWN	ROAD - P		, MD 21208
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	on each line.	M	ocard		-Marc	tion	Approximate Interval Between Onset and Death
	ficate be executed ficate be executed in physician and in the burial-transit and in the burial-transit in the	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence to	ence of):	nang 1	Artery	Diseo	15€	y-ears
18, 20	ecords, P.O. Box 68, law requires that the death certificate as been signed by the attending phy 2 should be detached for use as the	Physician/Medic	in the past 12 months?	yes, outcome pf pregnar □Live birth 2 □ Fetal □Pregnant at time of de □Unknown	death 3	Ectopic pregnancy	у		23d. Date of deli Month	very Day Year
7	rdS, P quires that n signed b	b	Part II. Other significant conditions contribut	ing to death but not resul	Iting in the u	nderlying cause giv	ren in Part I.	23e. Did tobac		the cause of death? obably 4 □Unknown
!	I KeCO The law re ate has bee	Completed						24a. Was an autopsy performed	prior to d	ntopsy findings available completion of cause of 2 No
S SCHWARTZ	UNISION OF VITAI HECOTIAS, P.O. BOX 6  To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be (	1 ☑Natural 5 ☐ Pending investigation	al: 1   Inpatient 2   E a. Date of Injury (Month, Day Year)  e. Place of injury - At hot building, etc. (Specify	ER/Outpatier 28b. Time o Injury me, farm, str	28c. Injul Wor M 1	er: 4 🗷 Nursing H	th (Check only one) ome 5  Residenc 28d. Describe how 28f. Location (Stree City or Town, S	injury occurred et and Number or Ru	
DORIS	To the Hospital or within 24 hours afte To the Funeral Dir	Medical C				vestigation, in my	opinion, death occu	rred at the time, date	and place, and due	e to the cause(s)
•	With Took	Z	29b. Signature and title of certifier	Wigh	+, M	29c. Licens	274	O J	Date signed (Month	n, vay, Year)
	Ų		30. Name and address of person who complet  ERNESTINE WRIGHT, M		ULANE	Print) Y VALLEY	ROAD TI	MONIUM, MI	21093	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	San togratian's Signat	A A	AP .				

4:40 A.M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 19 1:30 George Α. Smith July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
March 5, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**X** M 2□ F 215-01-3689 91 1916 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Md. Baltimore Ruxton Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1407 Maywood Ave. 21204 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Captain Fire Department 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbur S. Smith Olive L. Siepp ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mr. Wilbur Smith/ Son 1407 Maywood Ave. Ruxton, Md. 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Prospect Hill Cemetery 7-24-07 4 ☐ Donation 5 ☐ Other (Specify) Towson, Md. 21. Signature of Fu ral 1 rvio Licen 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinatory arrespondent. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Right disease or condition resulting in death) to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examine Due to (or as a consequence of): Physician/Medical of delivery Day Year ute to the cause of death? ☐ Probably 4 Unknown ere autopsy findings available or to completion of cause of

**Physician** /Medical Examiner

the Maryland a or 28a-f show the notified at

Items 23a o

"natural", or

the Medical

7 is marked other traumatic event, ti

Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

and attending physician for use as the buria the signed by the detach Be Completed by has Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day
	s contributing to death but not resulting in the underlying cause given In Part I.		use contribute to the cause
		24a. Was an autopsy performed?	24b. Were autopsy findi prior to completion death? 1 □ Yes 2 No
25. Was case referred to medical	26. Place of I	Death Check onl one	
examiner?	Hospital: Other: Other:		

examiner/ 1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA Other: 4   Null	rsing Home 5 Residence 6 Other (Specify)
27. Manner of Death  1 ☐ Natural 5 ☐ Pending  2 ☐ Accident investigation	SUIVI ZCO / WWW.	28d Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Plike injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1407 Lacywood Aug RuxTov May Vand 21204

29a. Certifier

Home RUXTON Meryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

20,2007 ble Hill CT. Luthonville, Md 21093

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

200

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#7 perFH G869 7/25/07 WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 20, 7:40 A. M July 2007 Benita Bosch Tracey 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Catonsville 112 Osborne Avenue 8. Date of Birth (Month, Day, Year) March 8,1936 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6 Sex 1 ☐ M 2 TX F Missouri 71 219-32-4967 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 ☐Yes 2X No Catonsville Maryland | Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 112 Osborne Avenue Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 X No Specify Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orpha Holton Henry Esco Bosch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 112 Osborne Avenue; Catonsville, MD 21228 Robert H. Tracey Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Baltimore, Maryland 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 7/23/2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ter ing Asi on Schwal Mitzle Funeral Home of Catonsville, Inc. 21. Signature Funeral Servic icense 21228 1630 Edmondson Avenue; Catonsville, MD 23a. Part1. Enter the dise tie, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MOUTH ETASTATIO Due to (or as a consequence of) Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify) 1 ☐ Yes 2x No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М

Examiner requires that the death certificate be executed physician and s the burial-trans Box 68760. as attending p P.0. s been signed by the should be detached Division or Vital Records, certificate has page 2 Physician: this funeral

Examiner

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

Completed by

Be

2

**Funeral** 

Director

jes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Pages 1

permit. Page Department o Important: If any injury or

**Physician** /Medical

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.

Physician/Medical

2 Completed Be 2 Certification:

Medical

State

Registrar

2	c Certifier Check only e)	
29	Signature and	lt

Name and addre

2 Accident

3 Suicide

4 Homicide

prtifying P dical E

6 ☐ Could not be

and mann r stated

o ian: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

er: On the ball is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

OD CATON HVE. BANTIMORE

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HUAP!

31. Date filed (Month, Day, Year) JUL 2

3 2007

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Amend #10g, perFH,0869, 7/23/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year ear 0600 /Medical 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Nurs, A Harris 17-Age (In yrs. last birthday) GEUrajes Virke 5. Social Security Number Year If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F Months Days Hours Min. Year Director lana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 ethors any Injury or other traumatic event 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MID Laurel 1 ☐ Yes 2 ☐ No Prince Georges 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 9001 20 by Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Waitress Food Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Workman Sr Emily Cypert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Workman / Mother 6013 39th Avenue Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 4 Donation 5 Dother (Specify) 7/12/2007 Catonsville, MD 21. Sig uture Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring RD Laurel MD 20707 from & well 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) amplication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to (or as a ponsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1☐Yes 2☐No 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably peen s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a. Was an has autopsy performed? certificate 2□No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 3□ DOA Certification: To 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of eath 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation (Month, Day Year) 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, warne and address of person who completed cause of death (item 23a) (Type, Print) 31. Date filed (Month, gay Year) 32. Registrar's Signature State 3 Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		Certificat					Reg. No.		03	505
-fi	Physicia	an	Decedent's Name (First, Middle, La  James	E.	Whit	nev				Date of De Month	Day	Year 2007	3. Time of 7:40	
4	/Medic	al	4a. Facility Name (If not institution, given		WILL		Town, or	Location				ounty of Death		Р
	Examin	er	16300 Dahl Road			Laure	_				Pri	nce Georg	ges	
	Funeral Director		5. Social Security Number 6. \$ 417 - 22 - 0515	Sex 7. Age (In	n yrs. last birth 80 Y			If Under Hours	Min.	B. Date of Bi (Month, D. Sept. 2	ay, Year)	9. Birth Coo Alaba	nplace (State o untry) ama	or Foreign
	ne Maryland 8a-f show ptified at	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Prince Geo		c. City, Town						10a Citize	en of What Co		ity Limits 2 ☐ No
	h with the 23a or 2		10e. Street and Number 16300 Dahl Road			10f. Zij	707				United	States	America	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 ☐ Yes	cify Cuba	an, Mexica	ın, Puerto R	ify Yes or N ican, etc.)	5		e, etc. lack	
15-0	iin 72 ho n "natur fedical	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)  College (1-4or 5+)	1111	Decedent's Usu 'Give kind of we life. DO NOT u	rk done	during mo	st of working	7	16b. Kind	d of Business/l	Industry	
212	ad with /giene er thai	Com		1	Log	istics		40.14.11		record and all all		overnmen	t	
pu	be file	Be	17. Father's Name (First, Middle, Las	t)					er's Name ( ine Dan		e, Maiden S	surname)		
r <u>y</u> a	hould d Mer marke matic	은	John Whitney  19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addres	s (Street				ber, City or	Town, State, 2	Zip Code)	
Ma	nd 2 saith an alth an 27 is i		Harriette Whitney / V		163	00 Dah1 1	Road I	_aure1	, Maryl	and 207	707			
Baltimore, Maryland 21215-0036	ges 1 al nt of Hea if item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	_Hemoval from State		Disposition (Na , crematory or			Da			ation - City or		
턡	artmen artmen ortant: injury		4 □ Donation ☐ Other (Spec		Arlingto	n Nationa 22. Name a			0ct. 3,	2007	Arlin	gton, Ce	metery	
Ba	permir Depar Impor any ir once		Man 8	Will.		1						oad Lau	rel MD	20707
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	polications that caused the yone cause on each line.  Prostate Cal  Due to (or as a concard only opans)	ncer onsequence o		de of dyi	ng, such a	s cardiac or	respiratory	arrest,		Approxima Interval Be Onset and	tween
8		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underway Cause (Disease or injury that initiated events	b. Due to (or as a co		f):								
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	onsequence o	f):								
P.O. Box 68	e law requires that the death certifical has been signed by the attending phi je 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf   1 □ Live birth 2 [ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other (s		y			2	3d. Date of de Month	livery Day	Year
	uires that i signed by d be deta	b	Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying	cause gi	ven in Par	t I.		i tobacco us	se contribute to	o the cause of robably 4 5	
or Vital Records,	aw us b	Completed									topsy rformed?	24b. Were as prior to death?	utopsy findings completion of	available cause of
Vita	Physician: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				hor:	ce of Death					
on or	ding Physi n. After this c funeral dire	ion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigati	28a. Date of Injury (Month, Day Y		ime of njury	28c. Inju Wo	4 🗆	2	ne 5 🖺 Re 8d. Describ		Other (Spe	ecify)	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e Place of injury	- At home, fai (Specify)	rm, street, facto				8f. Location City or 7	(Street and own, State)	d Number or R	ural Route Nu	mber,
	ne Hospital or 124 hours afte ne Funeral Dir	Medical C	29a. Certifier 1 X Certifying 1 (Check only one)	Physician: To the best of r aminer: On the basis of ex and manner state	xamination and	, death occurre d/or investigation	d at the ton, in my	ime, date opinion, c	and place, a leath occurre	and due to the	ne cause(s) ne, date and	and manner a place, and du	s stated. e to the cause	(s)
	To the l	Me	29b. Signature and title of certifier	Moncha	1 MD	2		se numbe			29d. Date	e signed (Mon	th, Day, Year)	
	12		30 Name and address of person who	o completed cause of deal	th (Item 23a) (	Type, Print)	atha	Q n	10					
.5)	St Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 2 3 200	32. Registrar's	Signature	and .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Walker Jr. 07 2007 16 10:07AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Hours Min. MD 06/26/1961 Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Middle River Baltimore 1 ☐ Yes 2X No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Koad 21220 226 1184 Kinaston 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walker. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Road Middle River, MD Wife Michelle G. 26 Kingston 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD Minity 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility allahin O. Greene Funeral STUCO 4905 York Road Baltimore MID 23a. Part1. Enter the disease, or complicati shock, or hear failure. List only one c that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Iday Hemorrhage Intracerebral /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, E. the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after Aboth Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient To the rusprime.

Within 24 hours after death.

To the Funeral Director: After this of the funeral directory. 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗹 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J. W. seller & 6/2007 36663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Dr. Stuart Willes Square Drive, Baltimore MD, 21237 9000 Franklin 31. Date filed (Month, Day, Year)
JUL 2 1 2007 32. Registrar's Signature Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** sandra 11 2007 Heree /Medical gerna dine 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number | 6. Sex If Under 1 Year Months | Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😿 F 219-70-8906 Days Hours Director Jan, 17, 1959 Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Preston Caroline 10e. Street and Number 10g. Citizen of What Country? Rogo USA Newton 21655 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Black Specify: 3 □ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custoner Service Rep. Contractor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marian Waller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston, Maryland 21655 Date | 20c. Location - City or Town, State Michelle Roberts 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Paradise Cemetery 7/21/01/Tr 22. Name and Address Facility Henry Fureral Home, P. A. Trappe, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee anelle l. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Immediate Cause (Final **Physician** Due to (or as a consequence of): Hemorrhage disease or condition resulting in death) /Mèdical Examiner 5 troke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and de detached for use as the bunal-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.0. 1□Yes 2▼No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed No the troper.... Within 24 hours after death. To the Funeral Director: After this certificate has been in the Funeral Director. After this certificate has been in the funeral director, page 2 should be a second to the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 12 Natural 2 Accident 28a. Date of injury (Month, Day Year) 28b. Time of Certification: 28c. injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D24188 7-12-2007 MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rowert Sc MS 219 5. W

2007

and

32 Registrar's Signature

- 50

JUL 23

Bennett

31. Date filed (Month, Day, Year)

3. Time of Death

10d. Inside City Limits

d

Year

15

Day

2 No

1 ☐ Yes 2 ☑ No

Registrar

State

Washington

Easton

Physici /Medic Examir

**Funeral** 

Physician

DIVISION OF VICAL RECORDS, P.O. DOX 06/00,
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

	1 - For State Registrar			Cei	tificate of	Death			40. 2C	007	-2350
an	Decedent's Name (First, Middle,     RUDOLPH	D.	ANZALO	NE ,	SR.		2. Date of Month JULY		ay 200	Year )7	3. Time of Deat
ai er	4a. Facility Name (If not institution,				4b. City, Town, o	or Location of De	eath		4c. County		h
	Citizens Care &				Frede		lan la			deri	
	5. Social Security Number  139-22-0550  Usual Residence of Decedent	6. Sex 1⊠M 2□F	7. Age (In yrs. Ia	9 Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	lin. B. Date of (Month) June	15, 1	928	New	nplace (State or For unity) Jersey
ctor	10a. State 10b. County Maryland Frede	erick		reder							10d. Inside City Lin 1 ☐ Yes 2 🔀
Director	10e. Street and Number 8400 River	Meadow	Drive		10f. Zip Code	201			Citizen of		
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-	19a. Informant's Name/Relationsh				ng Address (Street						
	Lydia Anzalone	/ Wife	last Fi			leadow D		1			and 2170
	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation		State Cel	metery, crer	sition (Name of natory or other pla	1	Date	_			Town, State
	' 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		Fre		c Cremato						Maryland
	21. Signatura of Pullstan Service C	19	0111-11		. Name and Addre						
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		complications that	caused the death.	Do not ent						1	Approximate
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 6 2007 Day **Physician** 9:26 A Ruth W. Arbuckle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert County Nursing Center Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
March 31 1914 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□ M 2√ F 532-12-0538 93 Missouri Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Calvert Port Republic 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2540 Aster Road 20676 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: white ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) educator music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadie Cordon Luther Abraham Weaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 840 Pearl St. Boulder CO 80302 Gordon Arbuckle-son 20b. Place of Disposition (Name of cemetery, crematory or other place July 6 2007 ate 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Funeral Home Alexandria Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Ts. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ournon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the aid be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Crowsal noemon 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an s certificate has be irector, page 2 s autopsy performed? 1□ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manoj Mathur, MD 110 Hospital Rd. Suite 305 Prince Frederick MD 20678

31. Date filed (Month, Day, Year) State Registrar JUL

29b. Signature and title of certifier

32. Registra Signature 2007

29c. License number

25

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ANBU ARTHUR Ju<sub>1</sub>v 07 2007 12:05A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery 6. Sex 7. Age (In vrs. last birthday If Under 1 Year \_If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F Months Hours Min 80 Director 220-53-9250 29, 1926 India Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10h. County r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 13913 Huxley Cove Court 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 'natural', or items dical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. þ Specify: Asian 3 XWidowed 4 ☐ Divorced Completed Pages 1 and 2 should be filed within 72 ho ment of Health and Mental Hyglene. ant: if item 27 is marked other than "naturury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Registered Nurse Healthcare Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Asirvatham ပ Gnanadeepam Asirvatham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur/Son Gerald G. 13913 Huxley Cove Court, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any Injury or 4 □ Donation 5 □ Other (Specify) George Washington Cem.7/13/2007 Adelphi, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Ave, Silver Spring, MD 20904 Nanc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) sestive **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq once of): Examiner The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy φ in the past 12 mon Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown After this certificate has been signed in funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/2/No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JUL

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Name and address

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person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

29c. License number

29d. Date signed/(Month, Day, Year)

07-05377 Karen Frey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Funeral	5	5. Social Security Number 6. Soci			I E o	Birthplace (State or reign New York
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MD 2 d 2 shou lith and I n 27 is 1	- 1	19a. Informant's Name/Relationship (Type, Print)  Pamela F. Wojtowicz/Sister  19a. Informant's Name/Relationship (Type, Print)	Edgewat			
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	Σ	29b. Signature and title of certifier  29c. License ni  O.C.M.I		]	July 14, 200	
		30. Name and address of person who completed cause of death (Item 23a)				
15		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, B	Baltimore, MD 2	21201		
S	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
Regis	strar					
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Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

an	Decedent's Na							2. Date of D Month		Day Ye		3. Time of Death
caf	Mace.							July	2	2007		5:41 p.
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	19a. Informant's	Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Number or R	ural Route Numi	ber, City	y or Town, Star	te, Zip C	ode)
	01an I	. Baker/	Husband		468	Pritts Re	oad Swa	nton, M	D 2	21561		
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			State of Maryland / Dep	artment of Health and Mertificate of Death		ene 2007	23514
-	Sec. 15	0.5	Registrar  1. Decedent's Name (First, Middle, Last)	Tanoato of Boats	2. Date of Death		3. Time of Death
	Physici		Francis Charles	Buckley Sr.	Month July	9 2007	4:40p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	- <del></del> - J	4c. County of Death	13.10P
	- LAGITIII	Č	College View Nursing Home	Frederick		Frede	rick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthp	nlace (State or Foreign
E	Director		189-03-2636		Sept. 6,		sylvania
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	Maryl f sho ied a	lor	Maryland Carroll Mt. Airy				1⊠Yes 2□No
	r 28a	Directo	Maryland   Carroll   Mt. Airy   10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	h with		906 North Main Street	21771		United Sta	ates
	ems a	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	an Indian,
õ	or its		1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No Specify:	, , , , , , ,	Specify:	eto.
2-003e	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates: WWII		1.4	W	ite
0	n 72   "nat	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ring	6b. Kind of Business/In	dustry
7	filed within 7 Hygiene. other than "r ent, the Med	Эшс	Elementary/Secondary (0-12) College (1-4or 5+)	vil Engineer		Federal Go	vernment
0	illed I Hyg other ent, 1	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, M.		V C I IIII C I
a	Aenta Aenta rked ric ev	To B	John Buckley	Margaret	t Martin		
a	and Nama		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Rur		City or Town, State, Zip	Code)
Z	and 2 ealth n 27 I			North Main Street,			
ore	Jes 1 of H If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of ematory or other place)	Date 2	0c. Location - City or To	own, State
altimor	ment tant: jury c		4□Donation 5□Other(Specify) St. Mich	naels Cemetery 7/13			aryland
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy fujury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Stauffer Funeral Ho	omes P. A		
	40 = 8 O		Man OVORNO 1	621 Opossumtown Pi	ike, Fred	erick. Mary	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arres	St,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	pathy			
	Examiner		Due to (or as a consequence) f):	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Juno		
	052	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	MEDYT TU	MARC		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	9			
ĵ	be executed ician and burial-transit	Еха	resulting in death) Last  Due to (or as a consequence of):		,		
2/00/0	ate be executed hysician and the burial-transit	dical	d				
ŏ	ng ph as th	Med	IF FEMALE:				-
S D D	ath ce trendi	an/I	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pr pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of deliver	ery Day Year
5	the a	hysician/Mec	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5	Other (specify)		Month	Day Tour
	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Δ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
ecords,	signe d be	d by	Fro Stage Renal a	licease	1 ☐ Yes		
Š	w req	Completed			24a. Was an	24h Were auto	ppsy findings available
<u> </u>	he lay e has ge 2	dm			autopsy	prior to co	impletion of cause of
ō	ificate or, pa	e Co	25. Was case referred to medical	Of Place of Page		VNo 1 ☐ Yes	2 □ No
>	/sicla	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other	th (Check only one	nce 6 □Other (Specia	5/)
5	g Phy er this eral c		27. Manyer of Death 28a. Date of Injury 28b. Time	Training The	28d. Describe how		у)
5	ath. ir: Aft	Certification:	1 √ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u> </u>	r Atte	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Stre	eet and Number or Run State)	al Route Number,
2	ital o rrs aft ral Di lled in	Ce		4			
	To the Hospital or Attending Physician: The law requires that the death certific To thin 24 hours after death.  To thin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 2				
	o the	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
	, (V		a de	D0060417		7/10/07	
	CX/AL.		30. Name and address of person who completed cause of death (Item 23a) (Type			1 1 1	
	1		Hemen shal up 600 Thomas	e Tolonoon Ma	Frede	VICK M	D 21702
	Sta	te	31. Date filed (Month, Day, Year) 32. Legistrar's Signature	hade			
	Registr	ar	JUL 1 1 2007 Bour De My				

		_	For State Amend #10f,	State of Ma <b>7–11–07</b> , p	ryland/D <b>per FHD</b> I	epartment of l Dertificate of	Health Death	and Mental F 1	1ygien Reg. N	e 200	1 23515
la.			Decedent's Name (First, Middle, La				-	2. Date of Month	Death	av Year	3. Time of Death
ш	Physicia /Medic		Carol Diane Brand	lt				July	9,	2007	2:15 P M
	Examin		4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town,		of Death	i	c. County of Dea	
1.00	<u></u>		Casey House	Sex 7. Age	(In yrs. last birt	Rockvill hday) If Under 1 Year		r 24 Hrs. 8. Date of	Birth	Montgome 9. Bir	thplace (State or Foreign
Б	Funeral Director		067-48-8190	1 ☐ M 2 🕅 F		rs. Months Days		Min. (Month	Day, Yea 22, 1	r)   Co	chigan
	put w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	daryla f sho ed at	ō	MD Montgome	27	Rockvi	11e					Y Yes 2 □ No
	the f	rec	10e. Street and Number	EL y	ROCKVI	10f. Zip Code			10g. C	Citizen of What C	ountry?
	h with	a D	929 Maple Avenue			20815			USA		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of If Yes, specify Cu	Hispanic C ban, Mexic	origin? (Specify Yes o an, Puerto Rican, etc.	r No-	14. Race - Ame Black, Whi	
36	s afte		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2X No	Specif	y:		Specify: Wh	nite
21215-0036	hour tural	Completed by	15. Decedent's E	Education	16a.	Decedent's Usual Occi	pation		16b.	Kind of Business	/Industry
15	in 72 in "na Medic	Bet	(Specify only highest gi	rade completed) College (1-4or 5	+)	(Give kind of work don life. DO NOT use retir	ed) ed)	ost of working			
21,	d with	E I		4		ographer	T 40 14:1	L. J. M (Files A. A.)			vernment
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Las	-				her's Name <i>(First, Mi</i> nryn Mario			
Уa	ould I Men narke	۵	Robert Henry Braz		19h	. Mailing Address (Stree					Zip Code)
Maryland	d 2 sh th and th and ?7 Is n traur					27 42nd Ave				98116	
ā,	tem 2		Deborah Brandt/s: 20a. Method of Disposition	ister	20b. Place of	Disposition (Name of ry, crematory or other p	(ace)	Date	20c.	Location - City o	r Town, State
Ü.	Page ent of nt: If i		1 ☐ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			eake Cremat		07/10/07	Be1	tsville.	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatore of Funeral Service Lice	enstee Otto	W01051	22. Name and Add Going Hor	ress of Fac	emation Se	rvice	P.O. I	Box 784 Lle, MD 21029
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	MO1251 the death. Do	not enter the mode of d	ying, such	as cardiac or respirate	ory arrest,	LAIKSVI	Approximate Interval Between
	Physician		Immediate Cause (Final	Breast C							Onset and Death
	/Medical		disease or condition resulting in death)		a consequence	of):					
Е	Examiner		Sequentially list conditions,	b		-0.					
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Hijus)	Due to (or as	a consequence	or):					
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence	of):					
8760,	sate be executed obligation and the burial-transit	dical E		d							
ၑ	tificating phy as the	a a			-						
Вох	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death					23d. Date of d Month	elivery Day Year
	ie dea the at hed fo	/sici	1 ☐ Yes 2 🏋 No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 ☐ Other (specify)					
P.0	that the de led by the de detached	F.	Part II. Other significant conditions	s contributing to death b	ut not resulting i	n the underlying cause	given in Pa	rt I. 23e.	Did tobaco	co use contribute	to the cause of death?
ds,	uires signé	d b							1 ☐ Yes	2 □ No 3 □	Probably 4XIUnknown
CO	w require been si should b	Completed						24a.	Was an	24b. Were	autopsy findings available o completion of cause of
Re	The la	m o							autopsy performed es 2	d? death	?
ita	s <b>iclan:</b> Th certificate rector, pag	Be C	25. Was case referred to medical				26. Pl	ace of Death (Check			
>	hysic this ce al direc	TO E	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpati		utpatient 3 DOA					pecify)hospice
0	Attending Physician: r death. ector: After this certifice by the funeral director, i		27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Inju (Month, Da			njury at Vork? □ Yes 2		cribe now i	injury occurred	
Sio	ttend death. stor: /	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 280 Place of in	iurv - At home, f	arm, street, factory, offi		28f. Loca			Rural Route Number,
Division or Vital Records,	l or Attencafter death Director:	Certification:	4 ☐ Homicide determine	building, e	tc. (Specify)	,			or Tòwn, S		
_	To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by the		29a. Certifier 1 XCertifying (Check only one) 2 Medical Expone)	Physician: To the best caminer: On the basis of	of examination a	e, death occurred at the	e time, date ny opinion,	and place, and due death occurred at the	o the caus time, date	se(s) and manner and place, and c	as stated. lue to the cause(s)
	o the ithin 2 o the omple	Medical	29b. Signature and title of certifier	and manner si	/	29c. Lic	ense numb	er	29d.	Date signed (Mo	onth, Day, Year)
			Muemiene	Wroho	2005	mo Do	06	4615	Ju:	ly 9, 20	07
	) ad		30 Name and address of person w	ho completed cause of	death (Item 23a)	(Type, Print)					
P			Genevieve Wroble	wski, M.D.	1355 P:	iccard Dr.	Rockv	rille, MD 2	20850		
	S <sup>.</sup> Regis	tate trar	31. Date filed (Month, Day, Year)	2007 32. Resist	rar's Signature	South.					

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State	State of Ma		epartmen Certificate				giene Reg. No.	07	23516
			Registrar  1. Decedent's Name (First, Middle, Last	·)					2. Date of De.	ath		3. Time of Death
	Physicia		Adaline Blanche	_					Month July	Day 0.5	2007	5:00 p <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give	street and number)	Ctr	4b. City,	Town, or Loca	ation of Death	OULY		nty of Death	
	Examin	ÇI	Carroll Lutheran V			I .	westmii Vestmii	nster			Carro	11
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birtl		1 Year If L	Inder 24 Hrs. ours Min.	8. Date of Birl (Month, Da	th v Year)	9. Birth	place (State or Foreign
	Director		215-16-4728	]M 2□ <b>4</b> F	89 Y	rs. Wortens	Days	ours Iviai.	July 9	1917		W. VA
	p _		Usual Residence of Decedent		10c. City, Town	or Location						10d. Inside City Limits
	show	_	10a. State 10b. County			Westmin	-t					1 ☐ Yes 2 ☐ No
	8a-1	Director	MD Carrol	Τ						10g. Citizen	of What Cou	ntn/?
	vith th	吉	10e. Street and Number			10f. Zip				rog. Citizeri		indy:
	s 23g	ral	804 Tuder Drive	12. Was Decedent 8	ver in U.S.	13 Was Dece	211		ecify Yes or No	- 14. F	USA Race - Ameri	can Indian,
	er de Itam	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?				nic Origin? (Spe lexican, Puerto	Rican, etc.)	E	Black, White,	
50	d within 72 hours after death with the Maryland jiene. I then "natural", or Itams 23a or 28a-f show The Medical Exame net must be Endiffied at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 ANO Sp	oecify:		Spe	cify: W	hite
9500-61212			15. Decedent's Ed	ucation	16a.	Decedent's Usua	1 Occupation	l	ina	16b. Kind o	f Business/Ir	ndustry
2	nin 72 In In	ple	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	(Give kind of wo life. DO NOT us	e retired)	g most of works	ng	T.7		<b>7</b> 0
7	filed within 72 Hygiene. othar than "na'ent, 'ne Medic	Completed	6			Cler					inghou	Se
	be filed ital Hygie od othar event, I	Bec	17. Father's Name (First, Middle, Last)				18.	Mother's Name	e (First, Middle	, Maiden Sun	name)	
<u>a</u>	should be to nd Mental I marked o	2	Russell Winfield	Thomas				Estella				
Maryland	s 1 and 2 should if Health and Men item 27 is marke othar traumatic		19a. Informant's Name/Relationship (7	ype, Print)		Mailing Address						p Code)
	l and 2 fealth im 27 i		Judith McGill/day	ghter		4 Tuder			-			· · · · · · · · · · · · · · · · · · ·
altimore,	of He of He fiten		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemeter	Disposition (Nary, crematory or o	ne of ther place)	07/0	9/2007		on - City or T	
Ĕ	Pages ment of I ant: If its ury or o		' 4 ☐ Donation 5 ☐ Other (Specify	)	Louder	n Park C				Balti		
ä	permit. Pages Department of I Important: If ite any Injury or or		21. Signature of Funeral Service Licen	500		2 <b>P1-11-2</b>	s <sup>a</sup> Tone	Fally Hon	ne and (	Chapel	, P.A.	01157
n	207 2 2		K. Som	NO				rton Roa			er, ML	Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olicati <b>ons that (au</b> sed one cause on each lir	10.	1		uch as cardiac o	or respiratory a	rrest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	Cirrho	SIS H	ver					3 months_
	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	of):						
	LAditille		Sequentially list conditions,	b. Due to (or as	a consequence o	201-						
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence (	21.3.					ļ.	
_	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of	of):	<u> </u>					
8760,	be e	alE	l l									
287		edical	`	. d								
×	death certifi e attending I ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		· []=				23d.	Date of deli-	
.O. Box	death a atte	ciai	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at	2 ☐ Fetal death time of death	3 □Ectopic p 5 □ Other (s					Month	Day Year
o.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown								
<u>.                                    </u>	es that igned to be det	γP	Part II. Other significant conditions of	ontributing to death b	ut not resulting ir	the underlying	ause given in	n Part I.	23e. Did	tobacco use		the cause of death?
<u>5</u>	w require been sig should b								1 🗆	Yes 2□N	o 3∏Pro	obably 4 Minknown
00	The law requires that the ate has been signed by the bage 2 should be detached.	Completed							24a. Was		4b. Were au	topsy findings available completion of cause of
Records,	The taw cate has page 2 s	mo							perf	ormed?	death? 1 ☐ Yes	
Division of Vital	i <b>cian</b> : Th certificate rector, pag	a l	25. Was case referred to medical				26	8. Place of Deat				
>	di Si	To B	examiner? 1 Tes 2 No	Hospital: 1 🔲 înpatie	ent 2 ER/Ou	tpatient 3 D	Other:	4 Nursing Ho	ome 5 🗆 Res	idence 6 🗆	Other (Spec	city)
0	Jing Ph n. After th funeral	L:u	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	ry 28b. 7	rime of	28c. Injury at Work?		28d. Describe	how injury of	curred	
<u>o</u>	andin ath. or: Af	Certification:	2 Accident investigation	1		М		2 □ No				
<u>\<u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u></u>	or Attancater death	tific	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, fa c. (Specify)	rm, street, factor	y, office			(Street and N own, State)	umber or Hu	ral Route Number,
	ital o rs aft ral Di	Cer		1				ļ				
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Medical Exam	ysician: To the best niner: On the basis o	f examination an	e, death occurred d/or investigation	at the time, o , in my opinio	date and place, on, death occur	and due to the red at the time	cause(s) and , date and pla	manner as ice, and due	to the cause(s)
	the I hin 2 the I nplete	Medi	one)	and manner st	ated.		c. License nu					h, Day, Year)
		~	29b. Signature and title of certifier			23		2035		7	114	6,2007
•	WSL						<i>V</i> 2	,				_ /
	10		30. Name and address of person who			(Type, Print)	W	entmins,	tes 1	40 ZI	57	
	Tag 2		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature			, /				
	St: Regist	ate rar	JUL 0 9	2007	en b	· Sie	81					
			00L 0 0	2001	~	- Partie						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Amend #26 per PHYS/FH	1 07-10-20	Alfically of D	eath	R	eg. No. 2 [] []	7 23517
	Physicia	an .	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Yea	
	/Medic	al	Victor Gerard  4a. Facility Name (If not institution, give street and number)	l Bag	3a 4b. City, Town, or L	ocation of Death	July 1	L 2007 4c. County of D	7:30 P M
7	Examin	er	3052 Averly Road		Ijamsv			Frede	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	if Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		208-09-3833 <sup>1</sup> ፟፟ M 2□F	92 Yrs.	Months Days	Hours Min.	Oct. 9,	1914 Pe	nnsylvania
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notifiled at	tor	Maryland Frederick	Monrovia					1 ☐ Yes 2 No
	h the or 28a	Director	10e. Street and Number	III OVIU	10f. Zip Code		1	0g. Citizen of What	Country?
	th will		3052 Averly Road		21754		1	JSA	
	r dea tems	Funeral	11. Marital Status 12. Was Decedent En Armed Forces?	ver in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	s afte		1 ☐ Never Married 2 ☐ Married 1 🕅 Yes 2 ☐ No If Yes, Give Year or Dates: 1		1 ☐ Yes 2 💹 No	Specify:		Specify: LT	hite
21215-0036	d within 72 hours after death with the Marylar giene. rr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occupat			16b. Kind of Busine	
212	filed within 72 Hygiene. vther than "na ont, the Medio	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+	life.	kind of work done du DO NOT use retired)	ring most of worki	ng		,
2	ed wit	Com	12	Crane	eman			Steel Pro	dution
Maryland	d tal	Be	17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, I	Maiden Surname)	
ž	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	은	Battista Baga  19a. Informant's Name/Relationship (Type. Print)	10h Maili	ng Address (Street an	Louise B		City or Town State	a Zin Codal
<u>S</u>	and 2 sho ealth and n 27 Is ma		Sarah Cario, daughter		Averly Ro				21754
<u>o</u>	s 1 ar f Hea item 3		20a. Method of Disposition		esition (Name of matory or other place)			20c. Location - City	
Ë	Pages nent of I ant: If its ury or o		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	y Memorial	1	2007	Donora, H	Pennsylvania
Baltimore,	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Licensee		Name and Address				
n	80 = 80		Man M. Derge	_ 2	26401 Ridge	e Road,	Damascu	ıs, Maryla	
			23a. Part Enter the disease, or complications that caused to shock, or healt failure. List only one cause of each line	the death. Do not ent e.	ter the mode of dying,	such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
1	Physician / /Medical		Immediate Caus Tinal disease or condition resulting in death)	gestive	HEART	FR	iLure	=	
	Examiner		Due to (or as a	consequence of):	HEART 10 CARd i	7/ 14	. Inn-t	laki	5131107
	51, 30	je.	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0121101					
	cuted nd ransit	Examiner	triat initiated events						
Ď,	e exe ian ar urial-t	EX	resulting in death) Last Due to (or as a	consequence of):					
68/60,	death certificate be executed e attending physician and d for use as the burial-transit	<b>fedical</b>	d						
	certific iding p	/Me	IF FEMALE: 23c. If yes, outcome p	of pregnancy				Old Date of	deliver
Ř	atten for u	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  25c. If yes, outcome past 12 Live birth 2 4 Pregnant at t	2 ☐ Fetal death 3 ☐	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	Day Year
j.	t the c by the achec	Physician/	9 Unknown 9 Unknown						
S,	The law requires that the death cer to has been signed by the attendir bage 2 should be detached for use	by P	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given	in Part I.	23e. Did tot	pacco use contribut	e to the cause of death?
Records,	equire een sig ould b	ted t					1 □ Y	es 2√No 3□	Probably 4 ☐Unknown
ပ္ပ	raw ras be	Completed					24a. Was a	y prior	autopsy findings available to completion of cause of
		Co					perform	med? death 2 d.No 1 □ \	
Vital	iding Physician: h. After this certifica funeral director, I	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Othor	26. Place of Death			
ō	Phy this	<u>۲</u>	1 ☐ Yes 2 ☐ No riospital. 1 ☐ Inpatien 27. Manner of Death 28a. Date of Injury		- OLI DOX	4 LI Nursing Hor		ence 6 Other (S	Specify)
Division	Attending r death. ector: After by the funer	ation	Matural 5 □ Pending (Month, Day 2 □ Accident investigation	Year) Injury		es 2 No			
<u> </u>	I or Attend after death Director: ,	Certification:	a Could not be	ry - At home, farm, str (Specify)	reet, factory, office	2	28f. Location (St City or Town		Rural Route Number,
5	itaio Insaft rai Di	Cer							
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner state and manner state.	examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, a nion, death occurr	and due to the c ed at the time, d	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	o the ithin 2 o the omple	Med	one) and manner state  29b. Signature and title of contifier	ea.	29c. License	number	2	9d. Date signed (M	onth, Day, Year)
i	- s + ō		> (Bm 1/stanle Mr	)	0.27	<44		7/7/1	22
,	1//h		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print)	)		1/0/0	/-
(	7/1		John W. Vitarello, Jr., MD,		s Johnson	Drive,	Frederic	k, MD 2	1702
	Sta	te	31. Date filed (Month, Day, Year) 32. Egistrar	r's Signature	hacks				

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** ANET COCHRAN 30 2007 18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BAITIMERE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 6/9/1944 (ear) Hours 1 M 2 X F 63 220-40-8618 West Virginia **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notlifled at MD Harford 1 ☐ Yes 2XINo Director Havre de Grace 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3728 Level Village Road 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2½ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black. White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2/2 No Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If Item 27 Is marked other 1 any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Doane Bonnie Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Cochran (Spouse) 3728 Level Village Rd. Havre de Grace, MD 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Darlington Cemetery 4 □ Donation 5 □ Other (Specify) 7/23/07 Darlington, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINAMATOSIS /Medical Due to (or as a consequence of): Examiner METASTATIC CANCER (POSSIBLE COLON, BRENT if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No , page 2 certificate | 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State

Registrar

29b. Signature and title of certifier

ADRIANA

JONE ! 31. Date filed (Month, Day, Year) 32 Registrar's Signature

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST

S. GREENE

AU4176435E9222

BAITI MORE,

29d. Date signed (Month, Day, Year)

July 18, 2007

State of Maryland / Department of Health and Mental Hygiene Junita Lashawn Chestnut 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Dar July 10, 2007 0836 hrs Junita Lashawn Chestnut **Medical Examiner** c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Washington Months Days Hours 577-02-7657 Director 09/18/1979 27 M 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Washington  $\mathbb{C}$ Director 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number USA 20019 4903 Alabama Avenue, SE #2 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married Yes Black Yes 2 X No specify: Specify Yes, Give Year Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) within 72 PG CO School 21215-0036 Food Services 12th .. Pages I and 2 should be filed within tment of Health and Mental Hygiene. tant: If item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Belinda Knight Ronald W. Chestnut Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD 5131 Fitch Street, SE #304; Washington, DC 20019 Belinda Knight - Mother 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial Cem 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland 07/16/2007 Donation 5 Other Specify: 22. Name and Address of Facility Freeman Funeral 4594 Beech Road; Temple Fills, MD 21. Signature of Funeral Service Licensee errara Meerleur 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Cardiac aahythmia Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED attending physician of for use as the burial -^#535,PII,27,perME,g870, 8/13/07 TT The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE: 23b. Was decedent pregnant in the Year Fetal death 3 Ectopic pregnancy Month Dav past 12 months' Pregnant at time of death 5 Other (Specify) ned by the atter detached for u 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? signed by the bed be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 Yes No this certificate Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day, Year) Aftert 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No filled in by the fi Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 11, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Registrar's State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTEND of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month F Roy **Physician** 20 0 0 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 328 Steedman Pointe Rd. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept • 12 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 M M 2 F Maryland 83 1923 215-14-2312 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortant: I frem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mind has a contract. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Ellicott City MD. Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21042 3338 Coventry Court Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. nmed Folces! 1\XYes 2 □ No fYes, Give Year or Dates:1940-45 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White ģ 3 MWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Maintenance Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Julia Cash William L. Cash P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 328 Steedman Pointe Rd. Pasadena, Md. 21122 Carol Travers/Caregiver 20b. Place of Disposition (Name of cemetery, crematory or other place)
Shanks Church
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/11/07 Greencastle Pa. 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Lice 17225 45 S. Carlisle St. Greencastle, Pa. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final P **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last and Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No the 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 20 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Daughter's Other: 4 Nursing Home 5 Nursing Home 6 Nother (Specify Home 3□ DOA 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 2 within 24 hours after death.

To the Funeral Director: After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred completely filled in by the funeral 27. Manner of Death Certification: Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 20 30. Name and address of person MA m HARZ

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 23

32#Registrar's Signature

	B	For State egistrar	Certificate of	Death	Reg.  2. Date of Death		Time of Death
Physicia		Decedent's Name (First, Middle, Last)  William Eugene Che	ooks		Month Da		1710 hrs
ıl Examir		Ha. Facility Name (if not institution, give street and		4b. City, Town, or Location of Dear	July 5, 2007	4c. County of Death	
		rear of 100 Liberty Street	Hambery	Westminster		Carroll	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours Mi		MM/DD/YYYY) 9. Birthp Foreign	lace (State or Aaryland
Director	L	219-37-4563 1×M 2 F	16 Yrs		Jun 1,	1991 Court	Maryland
any.		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Locat	ion			0d. Inside City Limits
*	_	Maryland Carroll		Westmins	ster	1	Yes 2 No
2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Dire	10e. Street and Number 34 Liberty Street		10f. Zip Code 21157	1 -	Citizen of What Country USA	y?
h with	Funeral		Decedent Ever in U.S. 13. Wa d Forces? If Y	as Decedent of Hispanic Origin? (	Specify Yes or No- to Rican, etc.)	14. Race - America White, etc.	n Indian, Black,
or ite	Fun F	1 Yes	s 2 No	Yes 2 No specify:		Specify: white	e
rs afte	<u>a</u>	<ul> <li>Widowed 4 Divorced or Dates:</li> <li>Decedent's Education (Specify only highest or Dates)</li> </ul>		nt's Usual Occupation (Give kind o	f work done	6b. Kind of Business/Ind	
2 hour	Completed	, , , , , ,	during m e (1-4 or 5+)	nost of working life. DO NOT use re	etired)	G-b1	٠.
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Hygie Hygie other the M		17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma 11y Jane I		
d.be flental lental arked	Be	Harold Wesley Cheek  19a. Informant's Name/Relationship (Type, Print)	S 19h Mailin	g Address (Street and Number o	-	_	Zip Code)
ages 1 and 2 should be filed within 72 h nt of Health and Mental Hygiene. 1: If item 27 is marked other than "n other traumatic event, the Medical E.	٩	Harold W. Cheeks, fath		iberty Street,			
permit. Pages 1 and 2 should-be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	ŀ	20a Method of Disposition	20b. Place of Dispo	sition (Name of cemetery,	Date 2	20c. Location - City or To	own, State
uges 1 nt of F t: If i		1 Burial 2 Cremation 3 Remova	al from State South	Crematory 7	/9/2007	Winfield,	MD
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		Juste R. Dento	9	1 Willis Street	, Westmin	ster, MD 21	157
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Medical aminer		Immediate Cause (Final disease a. Horns	ing		A		Death
		or condition resulting in death) Due to (or a	as a consequence of):				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6ay **Physician** July 2007 2:30ам Viola A. Crawford /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore 6308 Collinsway Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2 🔀 F Hours Min 6/22/1919 88 218-07-6958 Director <u>Maryland</u> Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 🏖 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 6308 Collinsway Road permit. Pages 1 and 2 should be filed within 72 hours after death very popartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Trucking Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nettie Ekarius ဥ Walter Bergner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3865 Gray Rock Dr. Ellicott City, MD 21042 James Crawford, Jr./grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/9/2007 Glen Burnie, MD Glen Haven 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzkes Family FH, Inc. 21. Signature of Funeral Service Licensee M01442 4112 Old Columbia Pike Ellicott City, MD21043 5000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** metastati Colon Cancer 6m0 resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9□ Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? 1□ Yes No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20X No ဥ 1 TYes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

a rote MillerM Year) 1 0 31. Date filed (Month, Day,

29b. Signature and title of certifier

nave BALT MO 900

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

		1	For State Registrar	State of Maryla		artment of H			giene Reg. No.	07	23523
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Geoffrey Cheung					July			6:30 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or		Death		ty of Oeath	
		£	Montgomery Coun		spital . last birthday)	Olney If Under 1 Year		Hrs. 8. Date of Birt	h	9. Birthpla	ice (State or Foreign
	Funeral Director		5. Social Security Number 6. S 559–58–2971	M 2□F 66	Yrs.	Months Days		Min. (Month, Da 10/28/1	v. Year)	Hong	Kong
	70		Usual Residence of Decedent							10	d. Inside City Limits
	nylan show	_	10a. State 10b. County		ity, Town or L						1 ☐ Yes 2 K No
	Ba-f	Director	Maryland Montg	omery S:	ilver S	10f. Zip Code			10g. Citizen of	f What Count	ry?
	with the	Ö	5 Beechvue Court			20906	,	1	USA		
	hs 23	eral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.			n? (Specify Yes or No Puerto Rican, etc.)		ace - America ack, White, e	
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow ta Madical Evantinar must be notillised at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces?  1 X Yes 2 □ No 19  If Yes, Give 19  Year or Dates:	79-	1 ☐ Yes 2 ☒ No	Specity:	dono riboan, bro.,	Spec		Lnese
ŏ	72 hou	Completed	15. Decedent's E (Specify only highest gr	ducation	(Give	edent's Usual Occup	during most o	f working		Business/Indi	
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2	lygier har th		17. Father's Name (First, Middle, Last	5+	EXC	cutive	18. Mother's	Name (First, Middle			
yland	ould be fi Mental H arked ot atic evar	To Be	Shiu Kwai Cheung				Pok I	ling Lo			Codo
lar	2 sho		19a. Informant's Name/Relationship		19b. Mail 1720	ing Address (Street A	venue,	or Rural Route Numb Suite 26 Lanada N8X	B <sub>EAG</sub>	n, State, Zip i	C009)
e, 1	1 and Health am 27 thar t		Stephen Cheung/Br	20b	Place of Disp	osition (Name of	26 1	Date Date	20c. Location	n - City or Tov	wn, State
ō	ages nt of I t: If its / or o		1 ☐ Burial 2 🛣 Cremation 3	Removal from State	neral	ematory or other place Choices of	<b>f</b>	7/6/2007	Chanti	11v. V	irginia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If itam 27 is marked other than "natural; or Items 23a or 28a-1 ahow any injury or other traumatic evant, If at Medical Examination at ange.  Once.		4 □ Denation 5 □ Other (Special 21. Signature of Furieral Store Lice	ns d		22. Name and Addre	ss of Facility	Funeral Chantilly	hoices	of Cha	ntilly
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Re	he lav e has	m G						heq	opsy ormed? 2 🐼 No	death?	
ta	yaician: The is certificate hi director, page	O	25. Was case referred to medical				26. Place	of Death (Check only			
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0 0	ding Phy h. After thi funeral	lon;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury	Wo	ryat ⊮k? ]Yes 2∐N		how injury occ	curred	
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_	To the Hospitel or Attendwithin 24 hours after deall To the tuneral Director:	Medical Ce	(Check only 2 Medical Ex	Physician: To the best of my aminer: On the basis of examend and manner stated.	knowledge, de ination and/or	ath occurred at the ti investigation, in my	ime, date and opinion, deatl	place, and due to the n occurred at the time	e cause(s) and , date and plac	manner as si	tated. the cause(s)
	thin 2 the the	Med	one) 29b. Signature and title of certifier				se number		29d. Date sig		
)			) 3·~	of J. war				0	JULY		
	7		30. Name and address of person where some some some some some some some som	o completed cause of death (	item 23a) (Typ	e, Print) OERECK	RO Su	it, 213, 6.	AZTHER	58UR6	MARYLAND 20877
	SI Regis	ate trar	31. Date filed (Month, Day, Year)  JUL 09	32. Jegistrar's Si	gnature #	perte					

			State of State of Registrer		partment of Healt ertificate of Dea		ygiene 0 7	23524
Å		9.	Decedent's Name (First, Middle, Last)			2. Date of D	eath Day Year	3. Time of Death
	Physici /Medic		George Wills Coms	stock		July	15, 2007	1:20 P. M
)	Examin		4a. Facility Name (If not institution, give street and num 12852 Bikle Rd.	nber)	4b. City, Town, or Locat Smithsbur	-g	4c. County of Dea	on
	Funeral		White office	<ol> <li>Age (In yrs. last birthda)</li> <li>Yrs.</li> </ol>	Months Days Hou		Day, Year) Co	thplace (State or Foreign ountry)
35	Director		304-09-1738	92 Yrs.		Jan.	7,1915 New	York
	/land		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Many m-f eh	tor	Md. Washington	S	mithsburg			1 ☐ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show says figury or other traumatic event, the Madical Exocilirat rusal by notified at once.	il Director	10e. Street and Number 12852 Bikle Rd.		10f. Zip Code 2 1 78	33	10g. Citizen of What Co	
	death ms 2	nera	11. Marital Status 12. Was Dece Armed For		I. Was Decedent of Hispanic If Yes, specify Cuban, Men	Origin? (Specify Yes or N	lo- 14. Race - Ame Black, Whit	
920	urs after al', or its Ersomine	by Funerai	1 Never Married 2 Married 1 Yes ff Yes, Giv Year or Da	<sup>2□N</sup> 941-62	1 ☐ Yes 2 ☐ XNo Spe			hite
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gis	edent's Usual Occupation we kind of work done during	most of working	16b. Kind of Business	/Industry
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2	lied w Hygier her ti		17. Father's Name (First, Middle, Last)			lother's Name (First, Middle		artii
Maryland 21215-0036	ild be fi fental F rked ot ilc ever	To Be	George Frederick Comsto	ock	13.10	Ella Gardneı		
lary	and h		19a. Informant's Name/Relationship (Type, Print)		iling Address (Street and Nu			Zip Code)
S,	l and fealth m 27		Emma Lou Comstock (Wife		. Box 215 Smi	thsburg,Md.	21 /83 20c. Location - City or	Town State
Baltimore,	Pages nent of H		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 3  4 ☐ Donation 5 ☐ Other (Specify)	cemetery, ci	rematory or other place) urg Crematory	July 18, 2007	Smithsburg	
Balti	permit. Departr Imports eny Inju		21. Signature of Funeral Service Licensee		22. Name and Address of F J.L. Davis Fu	movel Hemo	12525 Bradbu Smithsburg M	254 (4)
			28a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause one	aused the death. Do not e	enter the mode of dying, suc			Approximate Interval Between
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	s that ned by deta	by Ph	Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause given in F	Part f. 23e. Did	d tobacco use contribute t	o the cause of death?
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H		Соп				pe 1 ☐ Yes	rformed? death?	s 2 No
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on	ding After fune	tion	1 Natural 5 Pending (Mont) 2 Accident investigation	of Injury th, Day Year) 28b. Time Injury		2 🗆 No		
Division of Vital Records,	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	ertification:	3 Suicide 6 Could not be 28e. Place	of fnjury - At home, farm, ng, etc. (Specify)	street, factory, office		(Street and Number or F Town, State)	lural Route Number,
	pital o	O	29a. Certifier 1 Dertifying Physician: To the	hest of my knowledge, de	eath occurred at the time, da	te and place, and due to the	ne cause(s) and manner a	s stated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the boone)	asis of examination and/or ner stated.	investigation, in my opinion	, death occurred at the tim	e, date and place, and du	e to the cause(s)
	within To the	Me	29b. Signature and title of certifier	$\supset$	29c. License num	ber	29d. Date signed (Mon	
			V ( Matas) a	n	DOC	50362	7/10	107.
	20		30. Name and address of person who completed caus  31. Date filed (Month, Day, Year)  32. R	se of death (Item 23a) (Typ	e, Print) Shure N	D 21783	3,	
U <sub>1</sub>	se Sta		31. Date filed (Month, Day, Year)	legistrar's Signature				
4	Regist	rar	JUL Z I ZUUI	the se for				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23525 Certificate of Death Reg. No. C. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Naomi Day 21:05 JULY 17TH, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Oct 9, 1930 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1□M 2□F Director 220-26-9630 76 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at WV Mineral Ridgeley 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 3 Box 412 26753 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if flear 27 Is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner musts by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌂 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify. Specify: 3 X Widowed 4 ☐ Divorced Year or Dates white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian WV Board Of Ed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Pleasant Redinger Raymond Redinger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 3 Box 412 Ridgeley WV 26753 19a. Informant's Name/Relationship (Type. Print) John Day son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 7/20/2007 Cresaptown MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA Signature of Funeral Ser 108 Virginia Avenue: Cumberland, MD 21502 The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cck, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death 2 DAYS Immediate Cause (Final CEREBROVASCULAR ACCIDENT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 2 ANO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After (Month, Day Year) 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

LAMM.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

WILLIAM, M.D.,

**ORIGINAL** 

The Art

900 SETON DRIVE, CUMBERLAND, MD 21502

29c. License number

25406

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

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						Cert	ificate	of I	Death		leg. No.			
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea		Year		ne of Death
	Physician		Addison Ruth	Dougle	as					Jula	Day	2007	9	1.16 AM
	/Medica Examine		la Facility Name (If not institution, give s	treet and number)				1	b. City, Town, or L		4c. Co	unty of Death		
	Examine	1	Shady Grove Advent	ist Hospi	ital				Rockvi	11e		Montgo	mer	У
	Funoral		5. Social Security Number 6. Sex		e (In yrs. last bii	rthday)	If Under 1		If Under 24 Hrs.		h ( Year)			tate or Foreign
	Funeral Director		212-79-2216	M 25tF		Yrs.		Days 21	Hours Min.	April 1	6.200		ryla	-
		h	Usual Residence of Decedent											
	ytency		10a. State 10b. County		10c. City, Tow	n or Loca	ation					1		de City Limits
	Mar Ag	<u>ַ</u>	Maryland Freder	ick	New Ma	rket							1 🗆	Yes 2⊠No
	t 28		10e. Street and Number				10f. Zip Co	ode			10g. Citizen	of What Cour	ntry?	
	3 Wit		5729 Meyer Avenue						21774		Unit	ted Sta	tes	
	daat	١		2. Was Decedent Armed Forces?	Ever in U,S.	13. W	as Deceder	nt of H	lispanic Origin? (Sp an, Mexican, Puert	ecify Yes or No	14.	Race - Americ Black, White,	can India	an,
9	at a la		1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 🔀 1	No		Tes, speemy		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ecify:		
8	urs	^	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		"	_ 163 20	a <u>r</u> 140	opoury.		J.	Wh:	Lte	
21215-0036	within 72 hours efter death with the Maryland ane. than "naturel" or Herns 23e or 28a-f show he Madical Exercises must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade		16e	(Give k	nt's Usual (	done (	during most of wor	king	16b. Kind	of Business/In	dustry	
21	E .	<u>ğ</u> .	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	O NOT use	retired	d)					
7	filed withi Hygiane. other than	<u></u>	0				None					None		
pu	be filed tai Hygid d other event, to	26	17. Father's Name (First, Middle, Last)						18. Mother's Nan	ne (First, Middle,	Maiden Su	mame)		
<u>a</u>	Menta	0	Charles Todd Dougl	as						Elaine				
Maryland	2 sho end I ie me	1	19a. Informant's Name/Relationship (Type	oe, Print)	19	b. Mailing	Address (S	Street	and Number or Ru	ral Route Numb	er, City or To	own, State, Zip	Code)	
	end seith		Charles Todd Dougl	as/Father	57	729 N	leyer	Ave	chue, New	Market	Mary	land 2	1774	4
re	oth oth		20a. Method of Disposition		20b. Place o	of Dispos	ition (Name atory or othe	of er plac	ce) 7/1	0/07	20c. Locat	tion - City or To	own, Sta	ate
Ĕ	Peges nant of nut: if its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ဩ Other (Specify)]	emoval from State Entombmen	t Resth	aven	Memo	ria	1 Garden	0/0/ S	Frede	rick,M	ary1	and.
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylen Depertment of Heelth and Mental Hyglane. Important: if item 27 is marked other than "naturel", or items 23e or 28s-f show eny Injury or other treumstic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service License	-					ess of Facility uneral Ho		۸			
ä	Ped Fed		b Todal Al	1 kmin	1/							le Marerel	and	21702
		$\dashv$	23a Part 1 Enter the disease or compli	cations that caused	the death. Do	not ente	r the mode	of dvir	umtown Pr	or respiratory a	rrest,	K mary		ximate al Between
			23a. Part1. Enter the disease, or complishock, or heart tailure. List only on	e cause on each li	ne.				•	, ,		1	Onset	al Between and Death
	Physician /Medical		Immediate Cause (Final				4					İ	0	1
	Examiner		disease or condition resulting in death) a	multion	gan sys	stm	failu	16			<del></del>	1	90	says
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	nsit 1	Ē	<b>₽</b> b	_anasa			of):					1	60	acrys
	deeth certificata ba executed e attanding physician and id for use as the bunal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or es e	consequ	ence or).					1	61	days
68760,	ba e siciar buri	<u>a</u>	Cause (Disease or injury that initiated events	extrem	e prem	natur	ity	_					0 1	uags
387	phys the	윷	resulting in death) Last		Due to (or as a	consequ	ence or):							
×	ing entire	Σ		l										
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o.	the de	<u> </u>	Part II. Other significant conditions con	tributing to death b	ut not resulting	in the un	dertying cau	ise gr	ven in Part I.					4 □ Unknow
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of Vital Records,	v requires that the deeth cobeen signed by the attand should be dateched for us	Completed by Physician			,	U		•	,	24a. Was	an autopsy	24b. W	ere aut	opsy findings
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=	sir idi	2	1 Tes 212 No	lospital: 1 Inpati			3□ DOA	·		lome 5 Resi			ify)	
u	a fee	<u>ۃ</u>	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Inju (Month, Da	lry Year) 28b.	Time of Injury		c. Inju Wo		28d. Describe	now injury (	occurred.		
Division	Attending r deeth. ector: After by the fune	g	2 Accident investigation				М		Yes 2□No	28f. Location	Ctroot and	Number or Du	ral Pout	o Number
Ξ̈́	r Att	[ ]	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In building, et	jury - At home, i c. <i>(Specify)</i>	farm, stre	et, factory,	office		City or To	wn, State)	regiliber or riu	ai rioui	e realizor,
Ω	is af	edicai Certification:											-1-1-4	
	t hour une aly fil	Cai	29a. Certifier 1X Certifying Phys	nar: On the basis o	f examination e	ge, death ind/or inv	occurred at estigation, i	the ti	me, date end plece opinion, death occi	e, and due to the urred at the time,	date and p	nd manner as lace, and due	to the ca	ause(s)
	To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: A completaly filled in by the t	8	one)	and manner st	ated.				se number			signed (Month		
	5 ¥ 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Σ	29b. Signature and title of certifier	.11 ==			290.							
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			30. Name and address of person who co		deeth (Item 23a	(Type, I	Print)	7	cive O.	ck. 115	Mazil	0. 1 21	1850	,
			A. Kimberly Infolia,	mo 491	of medi	ical	ente	V	rive Ro	UKVITTE,	iviata li	uno 20	000	
	Stat	<u> </u>	31. Date filed (Month, Day, Year)	32. egist	rer's Signature,		and a							

Registrar

DHMH 16 Rev 6/95

					Cei	tificate	e of i	Death			Reg. No.	UI		3061
Dhusia	·	1. Decedent's Neme (First, Middle, Las.	יי							2. Date of D Month	eath Day	Year	3. Tir	me of Death
Physic /Medi		CARLTON	ELWOOD		DISE					06		007	22	245
Exami		4e. Fecility Name (If not institution, give					4	b. City, To	wn, or Lo	cation of Dea		ty of Deeth		
		EDWARD W. MCCREADY ME						CRISE				ERSET		
Funeral		5. Social Security Number 6. Se 15. 230-50-3557	x 7. A (1M 2□ F	ge (In yrs. le		If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of B (Month, D 11/22	irth ley, Year)	9. Birthp	lace (St	tate or Foreign
Director			VIII 201	72	Yrs.	i				11/22	/1934		RGIN	
and		Usual Residence of Decedent  10a. Stete 10b. County		10c. City.	Town or Lo	cetion						1	Od Insi	de City Limits
dery!	ō	VIDOTNITA ACCOMACI	,											Yes 2□No
the 1	5	VIRGINIA ACCOMACI  10e. Street end Number	<u> </u>	J.,	TANGIE	10f. Zip	Code	-			10g. Citizen o	What Cour		
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be filed within 72 hours after death with the Meryland ital Hygiene.  d other then "natural", or itema 23e or 28e-f show event, i'm Medical Examinat must be notified at	Funeral Director	11. Marital Stetus	12. Was Decedent	Ever in U.S	i. 13. V				ain? (Spe	cify Yes or N		ace - Americ	an india	an.
ter the	Ē	1 ☐ Never Married 2 Merried	Armed Forces	?						ecify Yes or N Rican, etc.)	Bi	eck, White,	etc.	
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Yeer or Detes:			I□Yes 2	No No	Specify:			Spec	ity: WH	ITE	
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gien g	5	10				WATE	RMAI	V			SI	EAF00[	)	
al H	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	e, Maiden Surna	ime)		
should the marked urmatic	<sup>2</sup>	ELWOOD DISE						MAI	RY PI	RUITT				
2 sh end is m	-	19a. Informant's Name/Relationship (T)			19b. Mailir	g Address	(Street	end Numbe	er or Rure	l Route Num	ber, City or Tow	n, State, Zip	Code)	
end 2 ealth e		EMMA DAWN DISE/SPO	DUSE		16159	PONDER	OSA_	LANE,	TANGI	ER. VA	23440			
Peges 1 nent of He nt: If Iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		ace of Dispo metery, cren	sition <i>(Nam</i>	e of			Date	20c. Location	- City or To	wn, Sta	te
men ant:		4 □ Donation 5 □ Other (Specify)	)_	NEW	TESTAM	IENT CH	URCH	CEMETE	ERY   C	07/04/07	TANGIE	R, VI	RGIN	NIA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Menylan Depertment of Health end Mental Hygiene. Important: if Item 27 is marked other then "natural", or itema 23e or 28a-f show enty highry or other traumatic event, if a Medical Examinar must be notified at once.		21. Signature of Fuyeral Service Licens	99	Ą	22	. Name and	Addres	ss of Fecilit	у					
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	ő a	23a. Part1. Enter the disease, or complete ock, or heart failure. List only o	ications that cause	d the death.	Do not ente	er the mode	of dyin	g, such as	cardiac o	r respiratory	arrest,	-	Approx	ximate al Between
Physician						,						1	Onset	and Death
/Medical Examiner		Immediate Cause (Final disease or condition		5//	201	(e	-					2	we	e55
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g Ph ler th		27. Manner of Death	28a. Date of Inju (Month, Da	Iry Zear) 2	28b. Time of Injury	28	c. Injury Work				how injury occu			
ath. r: Aft	atio	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Da	ly roar)	Hijury	М		Yes 2□I	No					
er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At hom	ne, farm, stre	et, factory,	office		2		(Street and Nun	ber or Rura	/ Route	Number,
tal or rs eft el Di			,								, 51,			
To the Hospital or Attending Physicien: within 24 hours efter death.  To the Funerel Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exemi	<b>ner:</b> On the basis o	f examinatio	ledge, death	occurred a	t the tim	ne, date and	d place, a	and due to the	cause(s) and n	nanner as s	ated.	use(s)
the hin 2 the ruplet	Med	oney	and manner st	ated.										
With Co.	-	29b. Signature and title of certifier	(Pan)			290.	License	number 2 9	3,7		29d. Date sign	, ,	∪ay, Ye	ar)
		Michael	Colle	o M	11)	/	/_	3/6	د_ ۱		//	2/0	2/	,
£ 8 11		30. Name and address of person who co	mpleted cause of c	death (item 2	23a) (Type, I	Print)	11	na	180	lus	Grand Grand	escr	00	in
EB 4		31 Date filed (Month Con Vest)	122 Da	ar's Signatu		201	u	1800	ru	house	5	-1-14		(9/3
Sta	te	31. Date filed (Month, Day, Year)	007	ur s signa(U	L	1 .							(	00/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 07, Month **Physician** Jennie M. DeMoizes 2007 July 11:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing & Rehab Center Frederick Frederick 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🐼 F 160-20-9859 90 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits ns 23a or 28a-f shov must be notified at Frederick Maryland Frederick 1 XYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 United States by Funeral rai", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced natural", Year or Dates Completed the Me Acal 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Pruss Mary Bogaszewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Roman / Son 5154 Dartmoor Pl., Frederick, MD 21703 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Page Department o Important; If I 4 ☐ Donation 5 ☐ Other (Specify) July 9, 2007 Frederick, Maryland Resthaven Crematory 21. Signature of uneral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. P nt1. Ent r the dise se complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease yrs. **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading Learning Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitai 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner state To the I within 24 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

5

State Registrar Robert L. Kaufmann, M.D. 300 West 9th Street, Frederick, MD 21701
31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

30. Name and address of person who completed

JUL 1 0 2007

32. Pegistrar's Signature

cause of death (Item 23a) (Type, Print)

Sports

D 13971

July 9, 2007

			Please Tyles  1- For State Registrar	pe or Print in amend ite state of Maryla			nk. Ensu 70 8-6-( of Health a of Death	ire All 97 and M		ene 2 (	ible.	2352
	Physic /Medi		Decedent's Name (First, Middle, Last)     Thomas Anthon		S				2. Date of Death Month <b>July</b>	Day 15	Year 2007	3. Time of Death 12:00 P
	Exami	ner	4a. Facility Name (If not institution, give streement)  Harford Memoria		al		wn, or Location o avre de		ce	4c. Count	y of Death <b>Harf</b>	ord
	Funeral Director		5. Social Security 8980 6. Sex 1 M  214-36 9089 1 M  Usual Residence of Decedent	7. Age (In y	rrs. last birthday). 6 Yrs.	If Under 1 \ Months D	Year If Under Days Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, ) 04/26/1	'ear) 9 <b>41</b>	9. Birthpl Count <b>Ma</b> 1	lace (State or Foreig try) <b>ryland</b>
	the Maryland 28a-f ehow	Director	10a. State 10b. County  MD Cecil	10c.	City, Town or Lor						10	0d. Inside City Limits
	with the	i Dire	10e. Street and Number  15 Parkway			10f. Zip Co	ode 21918		109	g. Citizen of	What Count	try?
5-0036	within 72 hours after death with the Maryland ene. Then "naturer", or itema 23a or 28a-f ehow he Madical Examiner must be notified at	by Funerai	11. Marital Status 12.	Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	I f		t of Hispanic Ori Cuban, Mexican	gin? (Speci, Puerto F	city Yes or No- lican, etc.)	14. Ra	ce - America ick, White, e	
	within 72 hours iene. 'then "natural", the Medical Ex	Completed		ompleted) College (1-4or 5+)	(Give I		done during most retired)	t of workin	g 16	b. Kind of B		lustry
12 N 00 N C/	be filed value Hygie of other levent, II.	Be Co	17. Father's Name (First, Middle, Last)	0	11	ruck I		r's Name	(First, Middle, Ma	Hau aiden Sumar		
χ <u>γ</u>	d 2 should be filed th and Mental Hygii 7 is merked other traumatic event, I	10	Jesse Evans  19a. Informant's Name/Relationship (Type,				Nola		retta Pi			
// 5/07 / Baltimore, M	C = 01 -		Carrie Lieske (N 20a. Method of Disposition  1	20toval from State	t. Paul':	atory or othe  Luth Name and A	eran ddress of Facilit	07/19 11 Sm		Aberderal H	- City or Tov leen, lome	MD
mas 7	Physician /Medical Examiner sicien and purial-transit	al Examiner	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ons that caused the dause on each line.  Due to (or as a constitution of the constitution)  Due to (or as a constitution)  Due to (or as a constitution)  Due to (or as a constitution)	eath. Do not enter  Sequence of: Sequence of: Sequence of:	vator	dying, such as  Cardi  Alizea	cardiac or avlu	respiratory arres er Q A cular	t,		Approximate Interval Between Onset and Death
1.0. Box 687	The faw requires that the death certificate I ste has been signed by the atlending physi page 2 should be detached for use as the t	Physician/Medic	in the past 12 months?  1 Yes 2 No 9 Unknown	If yes, outcome of pred 1 Live birth 2 F 4 Unknown	etal death 3	Ectopic pregr Other (specif	<b>(y</b> )				ate of deliver	ry Day Year
ords,	w requires th been signed should be de	ρ	Part II. Other significant conditions contrib	uting to death but not i	resulting in the un	derlying caus	e given in Part I.			2 🗆 No	3 Proba	
Nec Nec		Completed	OF Was seen referred to medical						270	d?/	death?	osy findings available of pletion of cause of 2 No
f Vital	Phyaician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hosp	ital: Inpatient 2	☐ ER/Outpatient	3□ DOA	Other		Check only one e 5 ☐ Resident	e 6 □Oth	ner (Specify)	)
Division of	Attending or death.	Certification:	1 atural 5 Pending 2 Accident investigation	8a. Date of fnjury (Month, Day Year) 8e. Place of Injury - Al building, etc. (Spe	t home, farm, stre	М	Injury at Work? 1 Yes 2 N	40	3d. Describe how Bf. Location (Stree City or Town,	et and Numb		Route Number,
Ω	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physicia (Check only 2 Medical Examinar:	in: To the best of my le On the basis of exam	knowledge, death	occurred at the	he time, date and	d place, ar	nd due to the cau	se(s) and ma	anner as sta	ited.
	To the P within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.			cense number	21		. Date signe		

State Registrar 31. Date filed (Mohth, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Dominick L Gonzale	1- For State	ate of Maryla		artment of rtificate of		l Mental		D N-	200	17 2353
Physician/	Registrar  1. Decedent's Name (First, Midd	le,Last)			-		2. Date of D			3. Time of Death
Medical Examiner	Dominick	Lawrence		Gonzalez			Month July 8, 2		Year	1851 hrs
•	4a. Facility Name (if not institution 3151 Buffalo Road	on, give street and num	nber)	41	o. City, Town, or L New Windso		ath .		unty of Death Jerick	1
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	<del></del>		Birth (MM/DD/	YYYY) 9. Bir Foreid	thplace (State or
Director	653-07-8136	1 X M 2 F	8	Yrs.	Months Days	.Hours N	Aug.	7, 199		ountry) Colorado
	Usual Residence of Decedent 10a, State 10b, County		Idon City	, Town or Location					<i>V.</i>	10d. Inside City Limits
Ow any	· · · · · · · · · · · · · · · · · · ·		Toc. City							1 Yes 2 X No
ryland	Maryland Fre	derick		Moun	t Airy 10f.Zip Code			10g. Citizen	of What Cou	
ith the Maryland 23a or 28a-f show notified at once,	13118 Manor :	Desisso			2	1771	0.0	Ü		,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic eyent, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	13110 manor .	12. Was Dece	dent Ever in U		Decedent of Hisp	oanic Origin? (		No- 14.		ican Indian, Black,
death with or items 23 nust be no	1 X Never Married 2 N	arried Armed For	rces?	If Ye	s, specify Cuban,	Mexican, Pue	rto Rican, etc.)		White, etc.	
ral", o		orced If Yes, Give Yaar or Dates:			Yes 2 X No					hite
hours Exam	15. Decedent's Education (Spe Elementary/Secondary (0-12)	, ,			s Usual Occupations of working life.			16b. Kind	of Business/	Industry
136 hin 72 than than	3	College (1-	4 01 3+)	C+	dont		15	Flor	10n t 2 K1	y School
5-0036 led within 72 ho Hygiene other than "na the Medical Ex	17. Father's Name (First, Middle	, Last)		) Stu	dent 1	8.Mother's Na	me (First, Middle			y SCHOOL
215 be file mtal H rked c	Victor Domini	ck Gonzale	z		Address (Street	Ann Ma	rie John	son-Ke	lling	ton
D 21 hould hould Mei is man atic ey	19a. Informant's Name/Relations	ship (Type, Print)								
MD and 2 sho salth and 2 sem 27 is raumati	Ann Marie John	son-Kellin		13118 Place of Disposit	Manor D		Mt. Airy	, Mary	land 2	21771 Town, State
Ore, jes la of He If ite	1 X Burial 2 Crematio	n 3 Removal fro		crematory or oth					ation - City of	Town, State
Baltimore, permit. Pages I an Oppartment of Hechinoperant: If ite mijury or other tr	4 Donation 5 Other S		Mt	. Olivet		4 = 1114	July 14, 2007			Maryland
Bal permi Depar Impo	21. Signature of Funeral Service	ato		8	E. Ridge	ville l				es, P.A. cyland 21771
Physician	23a. Part I. Enter the disease, o failure. List only one cause		used the death	h. Do not enter th	e mode of dying,	such as cardia	c or respiratory	arrest, shock,	or heart	Approximate Interval Between Onset and
	Immediate Cause (Final disease or condition resulting in death)									Death
		Due to (or as a	consequence (	of):						
ted nisit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	consequence	of):		The second				
executed an and al - transit	events resulting in death) Last	Due to (or as a d.	consequence (	of):						
be execuician and urial - tra	UNPENDED	AMENDED								
	IF FEMALE: 23b. Was decedent pregnant in t	ho	utcome of pre						ate of deliver	
certification of the second of	past 12 months?	I I Live Di	rtn ant at time of d	looth -	al death 3 L er (Specify)	Ectopic pre	gnancy	I MC	onth	Day Year
Box e death o the atten ed for us hysic	1 Yes 2 No 9 Un	known 9 Unkno	wn							(1)
P.O. ss that the gned by e detache	Part II. Other significant condi	tions contributing to	death but not	resulting in the u	nderlying cause g	iven in Part I.				the cause of death?
S, P uires t uires t ld be c		<del></del>								bably 4 Unknown
ord w req as bee shoul								topsy	prior to	utopsy findings available completion of cause of
Records, The law requires ficate has been sign, page 2 should be Completed							1 ✓ Ye	rformed? s 2 No	death? 1 ✔ Y	es 2 No
cian:	25. Was case referred to medica examiner?	Hospital		7		of Death (Che				
n of Vital Records, P.O. ding Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach on: To Be Completed by P	1 Yes 2 No 27. Manner of Death	28a. Date of	npatient 2	ER/Outpatient 28b. Time of Ir		y at Work?	rsing Home 5	Residence	occurred	er: Scene
nding nding th. : Aft	1 Notural	ding Jul 8, 20	Day,Year)	1730 hrs		res 2 V No		er fell off of		
Division tal or Attendi us after death. "al Director: A led in by the fi	2 🗸 Accident Inve	stigation 28e Place	of Injury - At I	home, farm, stree	t, factory, office b	uilding, etc.	28f. Locatio	n (Street and	Number or R	ural Route Number, City
Division o ital or Attending urs after death. ral Director: Aft illed in by the fume ertification:		Id not be (Specify)	Field				or Town Field of 31	n, State) 51 Buffalo R	oad, New V	Vindsor, MD
Hosp 24 ho Fune rely fi	29a. Certifier 1 Certifying F	hysician: To the best aminer:On the basis o	of my knowled	dge, death occurr and/or investigati	ed at the time, da	ite and place, a	and due to the c	ause(s) and mate and place,	anner as sta	ted. he cause(s)
To the within To the comple	29b. Signature and title of certifi	and manner st	ated.	,	29c. License					onth, Day, Year)
	10.1	11.4	A P		O.C.N	M.E.		July 9	, 2007	
<b>—</b> ,	30. Name and address of person	who completed caus	e of death (Itei	m 23a)	L					
\	Zabiullah Ali, M.D.	Assistant Medica	al Examine	r 111 Peni	n Street, Balti	more, MD	21201			
State	. 1111 -	1 2007 32.	gistrar's Signa	turb April	Wall of					
Registrar								OCM	*	

 $A^M$ 

6:55

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Pennsylvania

Black, White, etc.

29d. Date signed (Month, Day, Year)

White

20872

Approximate Interval Between Onset and Death

1. Decedent's Name (First, Middle, Last) **Physician** EUGENE HORNING **GEHMAN** JULY 8 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3730 HOOPER RD. NEW WINDSOR CARROLL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex Date of Birth (Month, Day, **Funeral** Year Months Days Hours 1 X M 2 □ F May 29, 67 1940 Director 173-32-1195 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show r 28a-f show notified at 10a State 10c. City, Town or Location 10b. County Directo Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or Items 23a or Medical Examiner must be 3730 Hooper Road Funeral 21776 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed - owner Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Weaver Weaver Gehman Esther Bowman Horning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Brubaker Gehman, wife 3730 Hooper Road, New Windsor, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any Injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hopewell Church Cem. 7/14/2007 4 Donation 5 Dother (Specify) Mt. Airy, Maryland 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service Licensee au 26401 Ridge Road, Damascus, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause has ach line. Immediate Cause (Final disease or condition resulting in death) 5 ever **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed j physician and as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as attending | for use as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes Completed has been

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 21**2**010 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2[No 1 🔲 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D22663

Md. 21157

State Registrar

DHMH 17 Rev 1/2001

the Hospital or Attending Physician:

After

within 24 hours after death To the Funeral Director:

Be

ပ

Certification:

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

4212 31. Date filed (Month, Day, Year) JUL 1 0 2007

Ridge

Registrar's Signature

westmenster

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type/Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:15 AM Gribble July 2007 Joseph Harvey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Nursing & Rehab. Center Annapolis 8. Date of Birth (Month, Day, Year, Nov. 15 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1**X** M 2□ F Ohio 80 Nov. 1926 Director 283–20–7676 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10d. Inside City Limits 10c. City, Town or Location 1 Tyes 2 XNo Director MD Calvert Lusby 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 United States 13109 River Terrace Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∑ Yes 2 No 1944— If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 Married 1□Yes 2∏ Ño Specify. Specify: white ģ 3 Widowed 4 Divorced 1946 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) businessman own business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gribble Wilma Miller Eugene ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13109 River Terrace, Lusby, MD 20657 Carol E. Gribble, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 07-03-07 | Alexandria, VA 22. Name and Address of Facility Sign ture of Funeral Service C. Rausch Funeral Home, P.A. PO Box 600 Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANTENIOSCIENOTIC CANdiovasculas **Physician** 4 eaus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transli Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part JI, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy page 2 2 ☑ No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient

this funeral s after death. filled in by

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

(Check only one) 29b. Signature and title of certifier

1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

weensbury Raffattsville Mid 20781 4203

State Registrar

31. Date filed (Month, Day, Year) 5 2007 JUL

32. Registrar's Signature

within 24 hours a

completely

07-05019 Sylvester Allen		State Registrar	or Print in Blace e of Maryland / D		ent of I	Health ar		al Hygiene	2 U	07 2053
Physic Medical Exam		1. Decedent's Name (First, Middle,L $Sy1vest$		Gray				2. Date of Dea Month July 1, 20	Day Year	3. Time of Death 1225 hrs
		4a. Facility Name (if not institution, of Thompsons Corner Road		-		. City, Town, o			4c. County of Dea	ath
Funera		1	Sex 7. Age (In	n yrs. last birt	hday)	If Under 1 Ye	_	T	rth (MM/DD/YYYY) 9. E	Birthplace (State or eign
Director			X M 2 F	37	Yrs.	Months Da	ys Hours	Min. 04/1	0/1970	Country) MD
nd show any,	<u>ا</u>	Usual Residence of Decedent           10a. State         10b. County           MD         Calv		c. City, Town	or Location					10d. Inside City Limits 1 Yes 2 X No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 424 Lake Dri	ve			10f. Zip Code 2	0657		10g. Citizen of What Co USA	ountry?
થેં ⊾		11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 X Divorce	12. Was Decedent Even Armed Forces?  1 X Yes 2  If Yes, Give Year		If Yes		n, Mexican,	in? ( Specify Yes or N Puerto Rican, etc.)	o- 14. Race - Am White, etc	
oursafter atural", o	d by	15. Decedent's Education (Specify	or Dates:		Decedent's		ation (Give I	kind of work done	16b. Kind of Busines	
0036 within 72 h jene. er than "n Medical E	Completed	Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)		-	ctric	ian		Electri	ical
215-( be filed trial Hygintal Hyginthe	Be Co	17. Father's Name (First, Middle, La William		Gray				s Name (First, Middle, $1dine$	Harri	is
AD 21 2 should b 1 and Mer 27 is mar	T <sub>0</sub>	19a. Informant's Name/Relationship Marlene Cooke		-	b. Mailing A	Address (Str			mber, City or Town, Str ke Beach	ate, Zip Code) , MD 20732
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", important: Triten 27 is marked other than "natural",		20a. Method of Disposition  1		cremat	tory or othe Roc	k Chr	.Cem		1	oublic, MD
Balt permit Depart Impor		21. Signature of Funeral Service Lic	Sevell		14	51 Da	res b	Beach Rd.	Funeral H Prince H	red. 20678
Physiciar /Medica Examine		23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)			ot enter the	e mode or dyrn	g, such as ca	ardiac or respiratory ai	rest, snock, or neart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequ	ence of):						
ted I	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent) d.	ence of):						
760, ficate be execute 3 physician and the burial - tran	dical	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in whe funeral director nace 2 should be detached for use as the burial. Trans	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23c. If yes, outcome  1 Live birth 4 Pregnant at tim 9 Unknown	المعاملة المعاملة	2 Feta	al death 3 er <i>(Specify)</i>	Ectopio	pregnancy	23d. Date of deliv Month	very Day Year
s, P.O. E ires that the d signed by the	Þ.	Part II. Other significant condition	s contributing to death b	ut not resultin	ng in the ur	derlying cause	given in Pa			to the cause of death?  Probably 4 Unknown
of Vital Records, ng Physician: The law requir Wher this certificate has been s	plete							perf		
Vital   hysician:	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/C	outpatient		Other	(Check only one)  Nursing Home 5	Residence 6 🗸 0	ther: Scene
ion of V tending Phy eath. tor: After th	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending		FO	Time of In	-	jury at Work	Operator o	e how injury occurred of motorcycle that	struck a fixed object
Division  To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A	Certification:	2 V Accident Investig 3 Suicide 6 Could r determi	ot be 28e. Place of Injury	y - At home, f	arm, street	, factory, office	building, et	or Town.		Rural Route Number, City anicsville, MD
To the Hosp within 24 hot To the Fune	<u> </u>	29a. Certifier 1 Certifying Phys	sician: To the best of my k ner: On the basis of examin and manner stated.							
£ ½ £ 8	₩.	29b. Signature and title of certifier	and manifer stated.			29c. Lice	nse number		29d. Date signed (	Month, Day, Year)

State Registrar Ling Li, MD Assistant 5 2007

32. Registrar's Signature

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

July 2, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 5 2007 Day Oloa D. Gurick 9:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solarans Nursing Center Solarans Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 Indianna **Funeral** Months Days 1□M 25F Hours 87 311-05-4205 Director Aug 26 1919 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural"; or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Maryland Calvert Solarans Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20688 13325 Dowell Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2X No ģ Specify 3 ₩ Widowed 4 Divorced WII Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Delich Yelka Blanusha ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 660 Colon Ave. St. Augustine, Fl 32084 19a. Informant's Name/Relationship (Type. Print) Michael S. Gurick - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Surial 2 ☐ Cremation 3 Removal from State Arlington National Cemetery July 23 2007 Arlington Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 以下の 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ORONAR isease weeks **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and burial-tra Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 TYes Completed evene 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes i or Attending Physician: after death. 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1. Natural Injury 1 Yes 2 No 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Anwar Munshi, M.D. 110 Hospital rd Suite 303 Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrans Signature

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

2007▶

JUL

Physician /Medical Examiner

the

death

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records.

or Attending Physician:

the Hospital

The law requires that the death certificate be

burial-trai physician as the l use Pol ed by the a signed | certificate has birector, page 2 s director. funeral After after death

Be Medical Certification: in by the within 24 hours a

To the Funeral C filled

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27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

25. Was case referred to medical examiner? 1 Yes 2 No

> 5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

Other: AN Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1□ Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

29c. License number D55559

29d. Date signed (Month, Day, Year) July 3, 2007

1 ☐Yes

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Maslen, M.D.

7525 Greenway Center Drive, #316, Greenbelt, MD 20770

State Registrar 31. Date filed (Month, Day, Year) 0 9 2007 JUL



MD

D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Frances Marian Gormley July 2007 6:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 23, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sav 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔏 F 577-30-0513 81 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 XYes 2 □ No Director Virginia Fairfax Great Falls 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 River Birch Drive 22066 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Examiner 1 Never Married 2 Married White 1 X Yes 2 □ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Law Firm 12 Accountant permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 Is marked other 1 any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Joseph Gormley Nora Tierney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Daley/Niece 85 River Birch Drive Great Falls, Virginia 22066 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 7, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 2007 Silver Spring, MD 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 2222 Wisconsin Ave., N.W. Wash., D.C. 20007 Approximate Interval Between Onset and Death 23a. Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Impediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Physician/Medical the as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 💆 No Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 24 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 X No page 1∐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

To the Hospital or Attendir
within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 0

filed within 72 hours after death with the Hygiene.

Baltimore, Maryland 21215-0036

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After

death.

Box 68760,

P.0.

Division or Vital Records,

Physician:

items 23a

or.

'natural",

State Registrar (Check only

29b. Signature and title of certifier

Anushiravan Dadgar, M.D. 31. Date filed (Month) Day, Year JUL 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

13219 Executive Park Terrace Germantown, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0051280

29d. Date signed (Month, Day, Year)

July 2, 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year M RICHARD 07 HIGSON 18 07 1940 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS 8. Date of Birth (Month, Day, Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Hours Months Days 1 M 2 □ F Μ̈́D Feb 12, 1939 215-36-9223 68 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√1Yes 2 No Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 1524 East Oldtown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married X Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CSX Transportation carman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Higson Seward Herbert Higson Maxine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 1524 East Oldtown Rd. Cumberland A. Darlene Higson wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/23/2007 Rocky Gap Veterans Cemetéry MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Furth 108 Virginia Avenue: Cumberland, MD 21502 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f sh Examiner must be notified

"natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If New 27 Is marked other than any injury or other traumatic event, the Manging.

Director

by Funeral

Completed

Be

2

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,  $\overset{\sim}{\varphi}$ 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Immediate Cause (Final disease or condition resulting in death)	a. Metasta  Due to (or as a consequence)	uence of):	sostile	Cancer.		Onset and Death Umlonom
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	uance of j				
dical Exar	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic			23d. Date of deliv Month	ery Day Year
ed by Ph	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacco		the cause of death?
Complet					24a. Was an autopsy performed? 1  Yes 2  X	death?	opsy findings available ompletion of cause of 2∐ No
Be (	25. Was case referred to medical		-	26. Place of De	eath (Check only one)		
	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Speci	fy)
Medical Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	
Sertifica	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, fact	ory, office	28f. Location (Street a City or Town, Sta	and Number or Run te)	al Route Number,
edical (		nysician: To the best of my known the second my known the basis of examination and manner stated.					
Me	29b. Signature and title of certifier	follund	2	29c. License number	78 0-7	ate signed (Month)	, Day, Year)

Registrar DHMH 17 Rev 1/2001

10

State

625 Kent Avenue Cumberland Maryland 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Annad Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artmer ertificat			ind M	lental I	Hygie Reg.	6 U	17	23	538
			Decedent's Name (First, Middle	, Last)							2. Date of				3. Time o	of Death
	Physici /Medic		Sharon E. Henne	essy							Month Ju1	у 6,	Day 2007	Year	7:0	00A M
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City,	Town, or	Location o	f Death			4c. County	of Death		
			15 Vista Avenue	9			Thur	mont					Frede	rick		
	Funeral		5. Social Security Number	6. Sex	7. Age (	In yrs. last birthda	/ If Unde Months		If Under 2 Hours	24 Hrs. Min.	8. Date of	Dav. Y	ear)	Cou	place (State	
	Director		220-50-9894	1 ☐ M 2 ☐ XF		59 Yrs.					July	16,	1947	Wash:	ington	. D.C.
	and w		Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, Town or I	ocation								10d. Inside C	City Limits
	Manyl 1 shp	ō	MD Freder:	i o la	n	hurmont									1 🗌 Yes	2 XNo
	the 28a	rect	10e. Street and Number	LCK		.Hulliont	10f. Zij	Code				10g	. Citizen of	What Cou	ntry?	
	3a or	٥	15 Vista Avenue				217	88				US	SA			
	death with the Maryland ims 23s or 28s-1 show rmust be rigitled at	Funeral Director	11. Marital Status	12. Was De		er in U.S. 13	Was Dece	dent of Hi	spanic Orig	jin? (Spi	ecify Yes o	r No-	14. Ra		can Indian,	
0	or Ite		1 ☐ Never Married 2 Marr	ied Armed F	2 🔀 No		1 Tes, spe	•		, Puerto	Rican, etc.	)		ck, White,		
200	rai',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	Dates:		1 LJ Yes	2 <u>M</u> NO	Specify:				Specii	Whi	te	
'n	72 h natu	Completed	15. Deceden (Specify only highe:	s Education	)	16a. Dec	edent's Usu e kind of wo DO NOT u	al Occupa nk done d	ation during most	of work	ing	16	b. Kind of 8			
7	vithin ne. hen	mpi	Elementary/Secondary (0-12)	College	(1-4or 5+)	Į.		se retired,	)			Ъ				
7	iled v Tygie ther t		12 17. Father's Name (First, Middle,	l acti		Waitr	ess		18 Mothor	de Name	/First Mis		staur iden Sumai			
and	ntal h	Be	John William Her								McC1			110)		
Š	hould d Me mark matic	은	19a, Informant's Name/Relations			19h Mai	ling Address	(Street a						State Zi	Code)	
Z	od 2 s lth ar 27 is 1 trau		Juan Rosa-Maldor		and		•	,						, 0.0.0, 2.,	3 0000)	
a,	Hea Hem Hem		20a. Method of Disposition	iauo/iiusp		20b. Place of Disc	ista A	ne of			Date		c. Location	- City or T	own, State	
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (S		State	cemetery, cr Chesapea		,		07/1	1/07	Be	ltsvi	11e.	MD	
	artm ortan injui		21. Signature of Funeral Service		1	-	22. Name a Oing					-				
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П			23a. Part1. Enter the disease, or	complications that	caused th									VIII	Approxima Interval Be	ite
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	/Medical		disease or condition resulting in death)	a. Due to	o (or as a c	consequence of):		1	400	41	<u> </u>			- 1	المحاد	111
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2	s bee	Completed	Tobacco Abuse	, .	/							Vas an	24b.	Were auto	opsy findings ompletion of	available
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>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 🗹 No	Hospital: 1	Inpatient	2 ER/Outpati	ent 3 D	Othe Othe	200				e 6 ∐Otl	ner (Speci	fy)	
5	neral		27. Manner of Death	28a. Date	of Injury oth, Day Y	28b. Time (ear) Injury	of :	28c. Injury Work	at		28d. Descr	ibe how	injury occu	rred		
101517	auth. or: At	atic	2 ☐ Accident investig	ation		,,,	М		Yes 2□N	No						
Š	r Att	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 288. Place	e of Injury ding, etc. (	- At home, farm, s Specify)	treet, factor	y, office				on (Stree Town, S		ber or Rur	al Route Nui	nber,
ב	urs of rel D				CONT. NO. 180		La company								Mark Siles	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours elter death: within 24 hours elter death: To the Funeriel Director. Alter this certificete has been signed by the attending it completely filled in by the funeral director, page 2 should be detached tor use as	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the Examiner: On the	basis of ex basis of ex	camination and/or	ith occurred nvestigation	at the time, in my op	is, date and pinion, deat	l place. h occur	and dua to red at the ti	the caus me, date	and place,	anner as : and due t	stated. o the cause(	(s)
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7			30. Name and address of person	who completed car	ise of deat	th (Item 23a) /Tun		, v ()	> /			1	july	0,00		
	az	1	William B A	FAVNES .	MIN	180		MAS	John:	Sen	Dr 1	781	Sp.c.W	MA.	007 21708	<b>&gt;</b>
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State

Registrar

GREGORIO

31. Date filed (Month, Day, Year)

M.

JUL 1 0

CHINABERRY DR. SALISBURY, MD 21801

BELLOSO, M.D. 5302

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sam John Hagina		State of Maryland / Department of Health and Mental F  1- For State Certificate of Death  Registrar		Reg. No. 201	17 2351
Physiciai Wedical Examin	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year	3. Time of Death 0609 hrs
Wedical Examin		Sam John Haginas  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deat	July 5, 20	007 4c. County of Deat	
		120 Calvert Towne Way Prince Frederick		Calvert	
Funeral Director		5. Social Security Number 458–80–4935 6. Sex 1 Number 59 Number 6. Sex 1 Numbe			orthplace (State or
ny	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nd show a	_	Maryland Calvert Prince Frederick			1 Yes 2 X No
th the Maryland 23a or 28a-f show any notified at once,	Director	10e. Street and Number 120 Calvert Towne Way 10f. Zip Code 20678		10g. Citizen of What Co United Stat	untry? Ces
after death with al", or items 23.	by Funeral	11. Marital Status  1 Never Married  2 Married  1 Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Year or Datas:  15. Decedent's Education (Specify only highest grade completed)  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puerto I Yes, Sive Year or Datas:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of	o Rican, etc.)	o- 14. Race - Ame White, etc. whj Specify: 16b. Kind of Business	
5-0036 led within 72 hours Hygiens Hyg	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Superintendent		construct	
21215-0036 Suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Con	17. Father's Name (First, Middle, Last) Pete Haginas  18. Mother's Nam Mary Vr		Maiden Surname)	
Should Band Mer	٩	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or		-	
atth	ŀ	Maryann Haginas - wife 120 Calvert Towne Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	Frederick MD 2 20c. Location - City of	
Baltimore, permit. Pages I an Department of He Important: If ite	-	1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metropolitan Funeral Service	,	Alexandria V	irginia
Baltimo permit. Page Department of Important: injury or oth	ł	21. Signature of Funeral Service Licensee 22. Name and Address of Facility		neral Home	
	1	5 Kaus C 4405 Brooties Is. Rd. P	ort Recub	lic MD 20676	
Physician /Medical Examiner	i	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	or respiratory ar	rrest, shock, or heart	Approximate Interval Between Onset and Death
w.*		Sequentially list conditions,  b	5.Vi.		
-	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (C. Due to (or as a consequence of):			
60,  Ite be executed hysician and e burial - transit		d.			
60, ate be ex hysician e burial	Medical	UNPENDED AMENDED		Lood Date of deliver	
certifica		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ancy	23d. Date of delive Month	ry Day Year
t the c		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute to	the cause of death?
S, P.O uires that t n signed by d be detac	ba ba	Cirrhosis of the liver		es 2 No 3 Pro	
of Vital Records, P.O. Box in Privilege Physician: The law requires that the death after this certificate has been signed by the artement director, page 2 should be detached for the control of the cont	Completed by		24a. Was auto		utopsy findings available completion of cause of
tal Rections: The certificate ector, page		25. Was case referred to medical 26.Place of Death (Check	1 Yes	2 No 1 V	es 2 No
f Vital Physician: er this certif	Ö	examiner?	ng Home 5	Residence 6 🗸 Othe	er: Scene
on of vending Ph. ath. br: After tl	fion:	27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe	how injury occurred	
Division pital or Attendi ours after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location or Town,	(Street and Number or R State)	ural Route Number, City
0 - 5 - 5	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To with To corr	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
		Joshe Jee no O.C.M.E.		July 5, 2007	
9	ļ	30. Name and address of person who completed cause of death (Item 23a)  Tocho Croopborg MD Assistant Modical Examinar 1111 Popp Street Baltimore M	D 21201	•	
Sta	fa	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M 31. Date filed (Month, Day, Year) 32. Refistrar's Signature	U Z 1ZU 1		
Registr		1111 6 2007 Breve & Goods			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Day **Physician** 7:28 рМ Margaret Harker July 5, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1009 Schindler Drive Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 95 Pennsylvania Director 298-09-7518 DEC 16, 1911 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a 20903 United States of America 1009 Schindler Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 Hes 1 Yes, Give Year or Dates: 21**X**(No Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify þ 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert McKay Ina Frow ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Schindler Drive; Silver Spring, MD 20903 Richard E. Harker - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 07-14-2007 4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave; Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Caydia erobic nevosc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consecuta real offi law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 Yes 2 No 1 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Afesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD # DOO 60 100 07-06-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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31. Date filed (Month, Day, Year)

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32. Figistrar's Signature

Baltimore,

Division or Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Nancy Marie Heilmann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 1□ F Yrs. Director 215-74-5737 52 1954 Nov. 10, Washington, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Adelphi with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 9203 26th Avenue 7 is marked other than "naturai", or items 23a traumatic event, the Medical Examiner must t 20783 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. à SpecifyWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Henry Shepherd ပ Elizabeth Ann Poetzman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: if item 27 is any injury or other trau once. Harry P. Heilmann/Husband 9203 26th Avenue, Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 11. July 1 € Burial 2 Cremation 3 Removal from State Moreland Memorial Park 2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Comp Comp nd Address of Facility 21. Signature of Funeral Service Licensee

Francis J. Collins Funeral
500 University Blvd, W., Si

23a. Parti. Enter the disease, or complications tha caused the death. shock, or hear failure. List only one cause on each line. Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring ,MD 20901 Immediate Cause (Final disease or condition resulting in death) Metastatac Physician eno carcino mu of unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the SS IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the a detached 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ HO 24a. Was an autopsy performe certificate or Vital 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 1 🔲 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Heilmann,

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Mont

29b. Signature and title of certifier

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Day,

7305

29c. License number

29d. Date signed (Month, Day, Year)

Elanouer PILWY Grewlett MD 20770

and manner stated.

32 Segistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#16a/bperFH7/17/07, BMW, MbCb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 6-29-2007 **Physician** Year Adolphe Huriaux 9:40pm M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Hebrew Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age Months Days Hours Min. F (Month) Day Year Montgomery 5. Social Security Number 262-05-7907 9. Birthplace (State or Foreign **Funeral** 1X7 M 2∏ F Boston, MA Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f ahow other traumatic avant, the Madical Exeminer must be notified at MD X□Yes 2□No Completed by Funeral Director Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 Taylor St 20815 United States items 23a should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Ukn 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 TNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Bureau of Scientific instrument Maker and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Standards Instrument Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adolphe Huriaux Jeanne Plancon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther L. Huriaux/ Wife Item 27 3700 Taylor St, Chevy Chase, MD 20815 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 permit. Pages Department of I Important: If It any injury or o Rock Creek Cemetery 7-6-07 Washington DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licerisee 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate or cause (Final disease or cause) Approximate Interval Between Onset and Death OF URINARY BLADDER **Physician** RCINOMA disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

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29b. Signalare and title of certifier

31. Date filed (Month, Day, Year)

MD

MD

32 Registrar's Signature

ATEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Hilbert Cheska July 5, 2007 P M He1en Jacobs 5:57 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 □ M 2 🛛 F 468-18-2921 87 August 1, 1919 Canada Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 X No Directo California | Los Angeles Culver City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3995 Overland Avenue, #305 90232 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Danie1 Cheska Marie Ann Riediger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Jacobs, 3995 Overland Avenue, #305 Culver City, CA 90232 husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Dopation 5 □ Other (Specify) Loudon Park Crematory 7/8/2007 Baltimore, Maryland 21. Signature of Funer Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, MD 20904 23a. Part 1. Enter the d'ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart frillure. List only one cause on each line.

Immediate Cause (Fin in disease or condition

a. AUTE MY OCALDIAL IN FARCTION resulting in death) Approximate Interval Between Onset and Death **Physician** INUTES /Medical Due to (or as a consequence of): Examiner ORONAKY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical the the attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð EMBOLISM 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After t 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 2 PHYSICIAN MID - AFTENDING 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

(Trace Brooke In Frankin, M.D. (8100 Stade School Road Sandy Spn)

Registrar

State

31. Date filed (Month, Day, Year)

09

2007

Baltimore,

Division or Vital Records, P.O. Box 68760

32. gistrar's Signature

#### 07-05253 Elizabeth K. Katz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Year 0915 hrs Elizabeth Kubis Katz **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Bowie 2936 Tallow Lane 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | if Under 24Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Foreign CountryNew York Months Hours Min 03/31/1948 Director 220-50-9913 59 M 2 X F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Prince George's Bowie MD items 23a or 28a-f show ust be notified at once. Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 2936 Tallow Lane 20715 USA Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married must Yes 2 X No White 3 X Widowed Specify. , Give Yea Yes 2 X No specify: Divorced the Medical Examiner ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Desert Shores timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 houment of Health and Mental Hygener strant: If item 27 is marked other than "may or other transmatic event, the Medical Exp Elementary/Secondary (0-12) College (1-4 or 5+) Community Association Accountant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Corcoran Be John R. Kubis 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8701 Jarwood Road, Rosedale, MD Kirk Thomas/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition timore, crematory or other place) ment of H tant: If it or other Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 07/13/07 Metropolitan Crematory tment Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Casch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease vamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed X UNPENDED #23a,27,perME,g869, 7/27/07 II ned by the attending physician detached for use as the burial 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Fetal death past 12 months Pregnant at time of death Physici Other (Specify) 5 Yes 2 No 9 🗸 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ş Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 V Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: director, Division of Vital Be examiner? Other 4 Hospital: 4 Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes 27, Manner of Death 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: Yes 2 No Pendina 24 hours after death. Funeral Director: the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie OCME July 10, 2007

Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year JUL 13 200 32. Registrar's Signatur State Registra

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND TITEM/3 Der PHYS G869
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month Physician 13, 8:30 am ANNA LITTLE JULY 2007 MAY /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner **EMMITSBURG** ST. CATHERINE'S NURSING CENTER FREDERICK If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days Months 1 □ M 2 🛛 F Director 89 JULY 1,1918 EMMITSBURG, MD 214-32-4991 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Department of Heelth and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumetic event, the Medical Examinal mantice notified at 10e. State 10b. County 10c. City, Town or Location 10d. toside City Limits 1 X Yes 2 No Director MD FREDERICK EMMITSBURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 306 S. SETON AVE. Funeral U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: WHITE ۵ 3 ☑ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 ELMER AGUSTA KRIETZ CATHERINE IRENE SHORB 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21 FAIRVIEW AVE., MERCHERSBURG, DA. 17236
Date 20c. Location - City or Town, State RONALD F . 20a. Method of Disposition LITTLE/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) SMITHSBURG CREMATORIUM 7/14/2006 SMITHSBURG, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility SKILES FUNERAL HOME 210 W. MAIN ST., Mon Les EMMITSBURG, MD. 21727 23a. Pert / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shocky, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physician encifor use es the buriel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, WILA Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ hes been sig ge 2 should b 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No this certificete or Attending Physician: : After this certifice s funerel director, Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ tnpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 1 Nursing Home 5 □ Residence 6 □ Other (Specify) 2 1 ☐ Yes 2 ☑ No 27. Menner of Death 28a. Dete of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Afte completely filled in by the fun 1 Naturel 5 Pending 1 Tes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only edical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JULY 13, 2007 30. Name end eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

State Registrar ALAN CARROLL,

31. Dete filed (Month, Dey, Year)

M.D

2007

33462 3

SETON AVE., EMMITSBURG, MD. 21727

310 S.

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Hubert Clarence Leonard, рм July 3, 2007 7:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4314 Westbrook Lane Kensington Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Ye Sept. 5, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Year) Days **¼**□M 2□F 041-32-0818 68 Director 1938 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

12 Is marked other than "natural", or Items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4314 Westbrook Lane 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. MXYes 2 □ No If Yes, Give Year or Dates: 1961–62 1 ☐ Never Married > Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify.White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Asssistant President Banking/Loans Banking/Loan# 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hubert Clarence Leonard, Sr. Mary Ann Delac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 :
Department of Health ar
Important: If item 27 Is
any injury or other trau Susan King Leonard/Wife 4314 Westbrook Lane, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. KenSlike 500 University Rlvd. W., Silver Spring, MD 20901 23a. P m. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Lung Cancer 3 Months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 2 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation

Division or Vital Records, P.O. Box 68760, funeral director, after death. the f filled in by

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Medical 29b. Signature and title of certifi

6 ☐ Could not be

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) DOU 410 72 7.5. 2007.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 Connecticut Avenue, Kensington, MD 20895 Azhar M. Z. Manipady, M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year) JUL 09





#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 5,2007 Sear Charles G. Lewallen 1330 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Year) 1/23/1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Min. Days Hours N.C. 1 € M 2 □ F 245-24-0200 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Garrett Park Montgomery 1 ☐ Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20896 10804 Kenilworth Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1X Yes 2 No 1942-If Yes, Give Year or Dates: 1952 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National College (1-4or 5+) Elementary/Secondary (0-12) Institute of Health Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Gorman Lewallen Gertrude Sexton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20896 Patricia Lewallen/Wife 10804 Kenilworth Avenue Garrett Park, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Reproval from State Chesapeake Crem. 7/06/2007 Beltsville, Md 4 □ Donation 5 □ Other (Specify) PHTLITPOODS OF TWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hronic Pulnonary Obstructive disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? wn

**Physician** /Medical Examiner

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.

Physician

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

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Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

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Vital Physician:

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Division

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Examiner Physician/Medical Completed by Certification: To Be

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27.

Medical

29a. Certifier

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

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						_				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were a prior to death?	complet	indings availa tion of cause of No
Was case referre	d to medical						26	Place of Dea	ath (C	heck only one)	·		
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Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	,	a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	'	Injury at Work? 1 ∐ Yes	2□No	28d	. Describe how injury	y occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28	e. Place of injury - At h building, etc. (Speci	ome, farm, stree	et, facto	ory, off	ice		28f.	Location (Street and City or Town, State)	d Number or R )	ural Rot	ute Number,

State Registrar

Pofferion 1201 Matthew MD Day, Year)

0 9 2007

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cks Koad \$200 Seven gistrar's Signature

1/ certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

To the Hospital within 24 hours a To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificate of Death Reg. No.											
Physic	ian/	1) 1. Decedent's Name (First, Middle,Last) 2. Date of Death										3. Time of Death
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		4a. Facility Name (if not institution	on, give street and n	umber)		4b. City, Town,	or Location of		,,		y of Death	
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Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum		21. Signature of Funeral Service			22.	Name and Addre	ss of Facility	Ben	nie S	mith	Fune	ral Home
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/Medical		failure. List only one cause				· · · · · · ·	122					Between Onset and Death
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876 tificat ng phy	2	23b. Was decedent pregnant in t	he 1 Live			etal death 3	Ectopic	pregnancy	,	Month		oay Year
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i, P.O ires that t signed b	by								1 Yes	2 No	3 Prob	ably 4 🗸 Unknown
ords, w requires s been si	Completed		-						24a. Was	an 124b	. Were au	topsy findings available
Orc aw re as be	鴽								autop	sy	prior to c	ompletion of cause of
tal Reco	performed?   death? 1 ✓ Yes 2 No 1 ✓ Yes									s 2 No		
tal R cian: 1 certific ector, p	5 0 25. Was case referred to medical 26.Place of Death (Check only one)											
Division of Vital Records, tal or Attending Physician: The law requir as after death.  Al Director. After this certificate has been s led in by the funeral director, page 2 should led in by the funeral director, page 2 should	B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 🗸 DOA	Other <sub>4</sub>	Nursing H	lome 5	Residence 6	Other	:
ing Phy After th	-	27. Manner of Death	28a. Date	e of Injury	28b. Time of		jury at Work?			now injury occu	urred	
nding h.h. e.fun	[등	1 Natural 5 Pen	(Mont	h, Day,Year)	Fnd appr	ox.	Yes 2 X		_			
Sio Viter deat ctor by the	l ₩ l		stigation Fnd	7/12/2007	11:30 a	#III			unk			
i i i i i i	lυl			ce of Injury - At h		et, factory, office	building, etc			tate) Ct. Se1b		ral Route Number, City
G: D at C ≥	tit	3 Suicide 6 X Cou	id not be		100				Monlo	t Solh	vzzillo	DH,
Division spital or Atten- tours after death neral Director:	Certification:	4 Homicide dete	Id not be some (Specify	resider	ice			4	Lapte	oc. ccib	yviiie	, 1/1
Divisior  Hospital or Attene 124 hours after death e Funeral Director: etely filled in by the		4 Homicide  29a. Certifier 1 Certifying P	hysician: To the be	st of my knowled	ge, death occu			ce, and du	e to the caus	e(s) and manr	ner as state	ed.
Div o the Hospital o rithin 24 hours af o the Funeral D		4 Homicide  29a. Certifier 1 Certifying P	hysician: To the beaminer: On the basis	est of my knowled of examination a	ge, death occu			ce, and du	e to the caus	e(s) and manr	ner as state	ed.
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the burial - trans	Medical Certific	4 Homicide  29a. Certifier 1 Certifying P	hysician: To the beaminer: On the basis	est of my knowled of examination a	ge, death occu	ation, in my opini		ce, and du	e to the caus	e(s) and manr and place, and	ner as state	ed.
To the Hospital of within 24 hours af To the Funeral D completely filled i		4 Homicide  29a. Certifier (Check only one)  2 Medical Exa	hysician: To the beaminer: On the basis	est of my knowled of examination a	ge, death occu	29c. Lice	on, death occ	ce, and du	e to the caus	e(s) and manr and place, and	ner as stated due to the	ed. e caus <b>e</b> (s)
To the Hospital o within 24 hours af You to the Tuneral D Completely filled i		4 Homicide dete  29a. Certifier (Check only one) 2 Medical Exa  29b. Signature and title of certification of the control of th	hysician: To the be iminer: On the basis and manner	est of my knowled of examination a stated.	ge, death occu	29c. Lice	on, death occ	ce, and du	e to the caus	e(s) and manr and place, and 29d. Date sig	ner as stated due to the	ed. e caus <b>e</b> (s)
To the Hospital o within 24 hours af To the Funeral D Completely filled i		4 Homicide  29a. Certifier (Check only one) 2 Medical Exa  29b. Signature and title of certification of the control of the con	hysician: To the be miner: On the basis and manner er	est of my knowled of examination a stated.	ge, death occu ind/or investigation	29c. Lice	on, death occurse number	ce, and ducurred at th	e to the caus	e(s) and manr and place, and 29d. Date sig	ner as stated due to the	ed. e caus <b>e</b> (s)
	Medical	4 Homicide dete  29a. Certifier (Check only one) 2 Medical Exa  29b. Signature and title of certifier one) 30. Name and address of persor Carol Allan, MD AS	hysician: To the be iminer: On the basis and manner er who completed cau sistant Medical	est of my knowled of examination a stated.	ge, death occu ind/or investiga OL (23a) 111 Penn	29c. Lice	on, death occurse number	ce, and ducurred at th	e to the caus	e(s) and manr and place, and 29d. Date sig	ner as stated due to the	ed. e caus <b>e</b> (s)
	Medical	4 Homicide  29a. Certifier (Check only one) 2 Medical Exa  29b. Signature and title of certification of the control of the con	hysician: To the be iminer: On the basis and manner er who completed cau sistant Medical	est of my knowled of examination a stated.	ge, death occu ind/or investiga OL (23a) 111 Penn	29c. Lice	on, death occurse number	ce, and ducurred at th	e to the caus	e(s) and manr and place, and 29d. Date sig	ner as stated due to the	ed. e caus <b>e</b> (s)

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State C Registrar	of Maryland /		ertment of H Tificate of L			jiene eg. No.	007	23551
	Physici /Medi		1. Decedent's Name (First, Middle, Last) George James McMillion					2. Date of Dea July		007 <sup>ear</sup>	3. Time of Death 8:25 P M
	Examir		4a. Facility Name (If not institution, give street and nu Carroll Hospice Dove Ho			4b. City, Town, or Westmins	Location of Death		4c. Cour Carı	nty of Death	
E.,	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 □ F	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth May 19	1925	9. Birthp Cour West	place (State or Foreign http:// Virginia
	e Maryland a-f show tified at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Carroll	10c. City, Tov		cation				1	10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 28 ist be no	al Director	10e. Street and Number 3705 Sue Dan Drive			10f. Zip Gode 21074		I .	0g. Citizen o USA	of What Cour	ntry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	1 ☐ Never Married 2 ☐ Married 1 2 ☐ Yell Yell Yell Yell Yell Yell Yell Ye	edent Ever in U.S. orces? 2 No ive 1943— Dates: 1945	- 1	Vas Decedent of Hi f Yes, specity Cuba ☐ Yes 2점 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	В	ace - Americ lack, White, cify: Whi	etc.
1215-	within 72 liene. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (	1-4or 5+)	(Give I life. E	ent's Usual Occupa kind of work done o OO NOT use retired, Logist	ation luring most of work )	ing	16b. Kind of	_	dustry
Maryland 2121	uld be filed Mental Hyg Irked other	To Be C	17. Father's Name (First, Middle, Last) Cecil Carter McMillion				18. Mother's Nam Viola W		Maiden Surn	ame)	
, Mary	and 2 sho saith and h n 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Helen Fitz — daughter			g Address (Street a		npstead,			Code)
Baltimore,	. Pages 1 tment of He tant: If iten jury or oth		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State cemete	ery, ciren .ead	sition (Name of natory or other place Cemetery	20	007	-	ead, I	own, State Maryland
Ball	permit Depart Import any in		21. Signature of Euneral Service Licensee	101490	93	Name and Addres  34 South	s of Facility El: Main Stro	ine Fune eet Ham	ral Ho pstead	me l, MD 2	21074
	Physician /Medical Examiner		Sequentially list conditions b.	etastat (or as a consequence	of):	er the mode of dying	g, such as cardiac		est,		Approximate Interval Between Onset and Death
28/60,	death certificate be executed e attending physician and id for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events co.	(or as a consequence							
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	in the past 12 months?	tcome pf pregnancy birth 2 □ Fetal death nant at time of death own		Ectopic pregnancy Other (specify)				Date of delive	ery Day Year
rds, r	w requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions contributing to d	eath but not resulting i	n the un	derlying cause give	n in Part I.		oacco use co es 2 □ No		ne cause of death?
L Kec	The lar ate has page 2	Completed						24a. Was a autops perform	v		psy findings available inpletion of cause of
r vita	di S	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1	Inpatient 2 ☐ ER/Ou	utpatient	Otho	26. Place of Death			ther (Specifi	, Hospice
VISION OF	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	ation: T	2 Accident investigation		Time of Injury	28c. Injury Work M 1 7		28d. Describe ho		` '	facility
	vital or At urs after d ral Direct lled in by	Certification:	4 Homicide determined build	of injury - At home, faing, etc. (Specify)				28f. Location (St. City or Town	, State)		
	the Hosp hin 24 hou the Fune npletely fi	Medical		best of my knowledge asis of examination ar ner stated.	e, death nd/or inv	estigation, in my op	inion, death occur	red at the time, d	ate and place	e, and due to	the cause(s)
	12 JA	2	29b. Signature and title of certifier	<u></u>			1502 1	11	9d. Date sign	o (Month,	Day, Year)
V	Sta	to	31. Date filed (Month, Day, Year) 32. F	se of death (Item 23a)	47	EAST	Mach	st. We	stivil	ister	hy zust
DHM	Registr	ar	JUL 1 1 2007	Genera &	19	book					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 8, 2007 1:30 A July DENNIS MATTHEWS ALLEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Princess Anne Somerset Manokin Manor Rehab & Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1⊠M 2□F June 26, 1931 Director Maryland 21**7-**28-4871 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "neturel", or Items 23a or 28e-f show The Medical Experimental be notified at 1 ☐ Yes 2 TNo Funeral Director Marion Station Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21838 TISA 5650 Crisfield Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes, 2 □ No 1948— If Yes, Give Year or Dates: 1956 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 1956 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Gas Pump and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fill if Health and Mental Hitem 27 is marked oth Be Clarence Benjamin Matthews Eva Mae Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if item 27 Carolyn Mahnkey (Sister) 4220 Jesterville Road - Tyaskin, Maryland 21865 other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Parial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ō Department o Importent; if eny Injury or once. ŏ Paul's Cemetery 7/12/2007 Marion Station, MD 21. Signature of Funeral Sergice Licensee 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASWD 5 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): 7 //e N Matthews attending physician that the death certificate be Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛂 No 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? completely filled in by the funeral 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 V latural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 TSuicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

1415. S. DIVISION 31. Date filed (Month, Day, Yeer) State

29b. Signature and title of certifier with

> SALISBURY 32. Registrar's Signature

> > ORIGINAL

NATESAN

29c. License number

Do57359

29d. Date signed (Month, Day, Year)

DR. 45HA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1 - For State Of Wild Registrar	•	Certificate o	f Death	vieniai ny	rgrene Reg. No.2	007	2355			
S	1. Decedent's Name (First, Middle, Last)				2. Date of D Month	eath Day	Year	3. Time of Death			
ian cal	Richard Lovayer McKnight,	Jr.			June	26	2007	4:55P M			
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Towr	, or Location of Death	1	4c. C	ounty of Death				
-	605 6th Avenue		Bruns				ederick				
	157 M OF	e (In yrs. last birtho 7.6 Yr	Months Day		8. Date of Bi	irth lay, Year)	9. Birthp	place (State or Foreigntry)			
	213-24-7965 List M 2	76 Yr	5.		July 7	7 1930	Mary	land			
	10a. State 10b. County	10c. City, Town o	or Location				1	10d. Inside City Limits			
ò	MD Frederick	Brunsw	ick					1 ☑Yes 2 ☐ No			
<u>10</u>	10e. Street and Number		10f. Zip Code			10g Citize	en of What Cour	ntry?			
<u></u>	605 6th Avenue		217			US		,.			
era	11. Marital Status 12. Was Decedent	Ever in U.S.		f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or N		I. Race - Americ	can Indian,			
Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ N If Yes, Give	No			o Rićan, etc.)		Black, White,	etc.			
by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	Korean	1 □ Yes 2 🔯 N	o Specify:		s	Specify: Whi	Lte			
ted	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occ	supation	king	16b. Kind	f of Business/In	dustry			
pge	Elementary/Secondary (0-12) College (1-4or 5	5+) (i	ife. DO NOT use ret	ne during most of wor red)	KINY						
ő	6		Laborer					truction			
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)			18. Mother's Nam			,				
2	Richard Lovayer McKnight,	Sr.		Buelah I	rene Ba	rrett					
	19a. Informant's Name/Relationship (Type. Print)	1		et and Number or Ru				Code)			
	Carl Richard McKnight, Son			ock Circle							
	20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State	20b. Place of D	isposition (Name of crematory or other p	(ace)	Date	20c. Loca	tion - City or To	own, State			
	4 □ Donation , 5 □ Other (Specify)	Methodi	st Church	Cemetery	6/29/07	Kemp	town, M	D			
	21. Signature of Funeral Service Licensee		22. Name and Add	ress of Facility Villiams F							
	Barbara A. Williams, Own		100 Pete	rsville Ro	ad, Bru	ınswic	k, MD	21716			
	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ne.	enter the mode of o	ying, such as cardiac	or respiratory	arrest,		Approximate Interval Between			
	Immediate Cause (Final disease or condition	CGRE	RRO - VI	+SCULAR	Acci	DENT	-	Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)  a. ACUTE CEREBRO - UASCULAR ACCIDENT  Due to (or as a consequence of):  b. ACUTE LEUKERIA - Type Under Terrain of the conditions,										
L	Sequentially list conditions.	E LEUK	EHIA -	type un	de TER	といいり		1 GEAR			
ine	cause Enter Underlying	a consequence of):		×1.							
Саш	Cause (Disease or Injury that initiated events resulting in death) Last	a consequence of):									
E E	Due to (or as a	a consequence on	•								
Completed by Physician/Medical Examiner	d										
/Me	IF FEMALE: 23c. If yes, outcome	nf pregnancy									
ian	in the past 12 months?	2 Fetal death	3 ☐ Ectopic pregnal			23	<ul> <li>d. Date of delive Month</li> </ul>	ery Day Year			
ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time or death	5 ☐ Other (specify)								
H.	Part II. Other significant conditions contributing to death but	ut not resulting in th	ne underlying cause	given in Part I.	23e. Did	tobacco use	contribute to the	he cause of death?			
d by	Hassatension			•		Yes 2□		pably 4"⊠Unknown			
ete											
ם					24a. Was		24b. Were auto prior to co death?	psy findings available mpletion of cause of			
ပ္ပ			<u> </u>		1□ Yes	2 <b>2</b> No		2□No			
Be	25. Was case referred to medical examiner?  1		10	26. Place of Dea	th (Check only	one)					
7	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie  27. Manner of Death 28a. Date of Injur		Ment 3 DOA		ome 5 Res			y)			
ion	1 Natural 5 Pending (Month, Day		ry W	ork?	28d. Describe	now injury o	occurrea				
icat	2 Accident investigation 3 Suicide 6 Could not be	Inv. At home form	, street, factory, office	□Yes 2□No	20f Location	(Ctrast and I	Number of Bure	d Courts Museum			
řtif	4 Homicide determined 200. Place of injuries	c. (Specify)	, street, factory, offic	6	City or To	wn, State)	vumber or mura	al Route Number,			
ŏ	29a. Certifier 1 Certifying Physician: To the best of	of my knowledge d	leath occurred at the	time, data and place	and due to the	0.00100/51	nd mannar to	tatad			
Medical Certification:	(Check only 2 Medical Examiner: On the basis of one)	examination and/o	or investigation, in m	y opinion, death occu	rred at the time	, date and p	lace, and due to	the cause(s)			
Mec	and marrier sta		29c. Lice	nse number		29d, Date s	signed (Month,	Dav. Year)			
	FG 1 CH	1		10587		1111	7 (12)	2007			
	Oeren I - Smith,	/4 . O	To Driet	10000	1 5000	360	7 10,				
	30. Name and address of person who completed cause of de GEORGE 1. SAITH L. J. ASS	21 CAL	pe, Print)	TOSPICE	ALLE	Car	~ (,00m	7 3.2			
te	31. Date filed (Month, Day, Year) 2007 32. Legistra	ar's Signature_	1 -	16 (KMIL	708.	1-KEL	rance	Day, Year) 2007 79 4D. 2170			
ar	JUL 1 0 2007	w the	answer.								

State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of Ma	aryland / Dep	artment of I			20007	20551.
	- Br		Registrar  1. Decedent's Name (First, Middle, Las	t)		Tillicate Oi	Dealli	2. Date of Dea	Reg. No. U U	3. Time of Death
- April Del	Physici /Medi		Verna	M	orris			Month July	4, 2007 Year	7:45 A M
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of Deat	h
+-			3741 3rd Street 5. Social Security Number 6. Se		e (In yrs. last birthday		h Beach I If Under 24 Hrs	. 8. Date of Birti	Calve	
	Funeral Director			M 2MTF	81 Yrs.	Months Days	Hours Min.		v, Year) Co	hplace <i>(State or Foreign</i> untry) Insylvania
Service	pu ,		Usual Residence of Decedent					1100. 2.	3,1923   FeII	
	Maryla -f shov ied at	힏	10a. State 10b. County  MD Calvert		10c. City, Town or L		Beach			10d. Inside Cify Limits 1 ☐ Yes 2 🌠 No
	n 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	23a cust be	a D	3741 3rd Street	-			20714		U.S.A.	
920	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give X Year or Dates:	Ever in U.S. 13.	Was Decedent of Hard If Yes, specify Cub		Specify Yes or No- to Rican, etc.)		
21215-0036	72 ho natur dical E	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		dent's Usual Occup kind of work done		rking	16b. Kind of Business/	Industry
121	vithin ine. ihan " e Ne	mpl	Elementary/Secondary (0-12)	College (1-4or 5	i+) lite.	DO NOT use retire	d) -	i		
	iled Hygi ther nt, t		17. Father's Name ( <i>First, Middle, Last</i> )		BLOUS	se Mill S			Textile  Maiden Surname)	
Baltimore, Maryland		To Be	Marshall	Han	delong		Hilo		Dock	er
Jar		N 8	19a. Informant's Name/Relationship (T)						er, City or Town, State, 2	
e, l	1 an Heal Heal Sm 2		Margaret Morris Gr	ove, daug			reet, Noi	rth Beach	20c. Location - City or	
nor	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☑ Donation 5 ☐ Other (Specify,		20b. Place of Disp		1		•	,
altir	+ E E = -		21. Signature of Funeral Service Licens		Anatomy (				Hanover, M neral Home,	
m	permi Depa Impo any i	1	William	R. Gr					ngs, MD 207	
is; TR			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause ou each lin	the death. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. CDY	00					Onset and Death
4	/Medical Examiner			Due to (or as	consequence of):					
e N est	- <b>35</b> 555 -	ier	Sequentially list conditions, if any, leading to immediate Cause Enter Underlying Cause (Disease or injury	b. ue to (or as a	a consequence of):					
	cuted nd ransit	Examiner	that initiated events	C.						
, 0,	cate be executed bhysician and the burial-transit	EX	resulting in death) Last	Due to (or as a	a consequence of):			· · · · · ·		
8760,	cate be executed physician and the burial-transit	dical		d	<del>-</del>					
Box 6	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	pf pregnancy				23d. Date of deli	von
. B	ed for u	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live birth 4 □ Pregnant at 9 □ Unknown		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> _	<u> </u>		Month	Day Year
P.0	that the	Phy	9 ☐ Unknown  Part II. Other significant conditions co		it not resulting in the ii	nderlying cause giv	en in Part I	23e Did to	bacco use contribute to	the cause of death?
Division or Vital Records,	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as	ed by						1 🗆 Y		obably 4 Unknown
eco	ne law re has bee je 2 sho	Completed						24a. Was a	n 24b. Were au	topsy findings available
Œ Œ	The yate has page	Som						autops perfor 1⊟ Yes	med? death? 2 No 1 ☐ Yes	ompletion of cause of 2 □ No
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Lau		th (Check only on	ne)	
0	Phys r this ral dir	은	1 Yes 2 No	1 ☐ Inpatier 28a. Date of Injury			4 🗆 Nursing H		ence 6 Other (Spec	eify)
ion	Attending Physician: r death. ector: After this certific by the funeral director,	tion	1 V Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Wor	k? Yes 2 □ No	200. Describe no	ow injury occurred	
<u>Vis</u>	or Atte ter dea irecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju- building, etc	ry - At home, farm, sti (Specify)	eet, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
Ω	ospital o hours af uneral D ly filled ii		29a. Certifier 1 ✓ CertifyIng Phy	siciona To the best s	f my knowledge, doet	h oppured at the ti			ause(s) and manner as	
	T 4 I 0	Medical	(Check only one)	iner: On the basis of and manner stat	examination and/or in	vestigation, in my c	pinion, death occu	rred at the time, o	ause(s) and manner as date and place, and due	to the cause(s)
	To the within 2. To the Complet	Ž	29b. Signature and title of certifier		0010	29c. Licens	e number	_ 2	29d. Date signed (Month	, Day, Year)
		-		ست	era	1166	14405	2	1-6-6	7
	4		30. Name and address of person who co				210 0~	an Francis	orials MD 2	0679
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	Signature	4		ice rreas	erick, MD 2	0070
	Registr	ar	JUL	9 2007	Essues &	Gosta	)			

DHMH 17 Rev 1/2001

State Registrar

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29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ata Moramedi MD

JUL 0 9 2007

Motama

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

**ORIGINAL** 

MO

32 Registrar's Signature

1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

11801 Prince Philip Dr. Olney,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Md 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** OSCAR DAVID MARTINEZ JULY 02 2007 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Institute of Health Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 **№**M 2 🗆 F 17 212-33-4592 Director 4/11/1990 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d, Inside City Limits 28a-f show MD MOntgomery Gaithersburg be notified Director 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 203 Summit Hall Road 20877 USA 23a Funeral Items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or lten ury or other traumafte event, the Medical Examinear ury or other traumafte event, the Medical Examinear. 1 Never Married 2 Married Affiled Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2□ No White El Salvador Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar David Martinez Silvia Yanet Brioso ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silvia Y.Brioso/Mother 203 Summit Hall Rd. Gaithersburg, Md20877 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Soul's Cem. Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donati ≠ 5 ☐ Other ( 3 Dimmoval from State permit. Page Department o Important; If any injury or once, 7/09/2007 Germantown, Md 5 ☐ Other (Specify) 21. Signatury of Funeral Service L PHILLIP AD RINKLDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to ( as a consequence of): 30 minz /Medical Examiner Sequentially list conditions Physician/Medical Examiner a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 X/10 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Inpatient 28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Year) 1 Natural (Month, Day Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation hours after death uneral Director: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in t within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

State Registrar

29b. Signature and title o certifier

Day,

2007

31. Date filed (Month, I DHMH 17 Rev 1/2001

Grobar MOTS642

PATRICK / JOSEPH GROHAR, 10 CENTER DRIVE, BETHESDA,

Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1764210

29d. Date signed (Month, Day, Year)

20892

MD

200

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		State	of Maryla	and / Dep <i>Ce</i>	artme <i>rtifica</i>				fental Hy	giene Reg. No	700	1	23557
		1. Decedent's Name	(First, Middle, L	ast)							2. Date of De	ath			3. Time of Death
	ician	Winifred	Mary	McMaho	n						Month July	Da Da	9 200 <b>7</b>	ar	9:45 a м
	dical niner	4a. Facility Name (If n	ot institution, g	ive street and n	umber)		4b. City	, Town, or	Location of	of Death	bary	-	County of I	Death	3.43
Lxai	milei		a Hoan	:+-1											
Funer		Holy Cros  5. Social Security Nur		Sex	7. Age (In v	rs. last birthday		er Sp or1Year	If Under	24 Hrs.	8. Date of Bir	1h	Montg		ry ace (State or Foreign
Funer Direct				1 □ M 2 🙀 F		Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)		Count	try)
		214-52-390 Usual Residence of D			<u> </u>						May 8	3, 19	930	Eng.	land
and ward			10b. County		10c.	City, Town or L	ocation							10	d. Inside City Limits
Mary 1 sh	ō														1 ☐ Yes 2 ☑ No
the 1	Director	Maryland 10e. Street and Number		gomery		Silve		ring p Code				10a Cit	izen of Wha		
with a	급	Too. Stroot and Humb	701				101. 2.1	p Code				Tog. Oil	12011 OI VVIII	Count	ır <b>y</b> :
hours after death with the Maryland ture!; or Items 23s or 28s-1 show at Exertinet must be nutified at	Funeral	12805 Va	alleywo						906				US		
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thin 72 hours and "natural", c	À	3E Widowed 4	□Divorced	Year or	Dates:								Specif <b>W</b> h	ıte	
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within 72 ene. than "net	lan	Elementary/Second	lary (0-12)	College	(1-4or 5+)	life.	DO NOT	ise retired,	)						
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d 2 should be file th and Mental Hy 7 is marked oth traumatic event		19a. Informant's Nam	e/Relationship	(Type, Print)		19b. Maili	ing Addres	s (Street a			A Route Numb		r Town, Sta	te, Zip	Code)
and 2 eaith a m 27 is		Mary C. Ma	allett/	Daught.	er	1281	ll Va	11evw	nood 1	Driv	e. Silv	er S	Spring	. MI	D 20906
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uires (1 signe	1 by					-	, ,	•			10	Vac 2	□No 35	Proba	bly 4 X Unknown
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ician: Th certificate rector, pag	O	25. Was case referred	to medical						26 Place	of Dooth	Check only o	1100	1 .0		E 140
Physician: this certific ral director,	0	examiner? 1 ☐ Yes 2 ☑ No	,	Hospital:	Inpatient 2	☐ ER/Outpatier		Othe			10 391				
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or At ter or irec	ertification;	4 Homicide	determined	28 e. Plac	e ol Injury - At ding, etc. <i>(Spe</i>	home, larm, str	reet, factor	y, office		1	28I. Location (: City or Tox			r Rurai	Route Number,
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To the Hospitel or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the fune.	edical	one)	moulcal EX8	and ma	nner stated.	nation and/or in	vestigation	i, in my op	iriion, deat	ui occurre	eu at the time,	date and	place, and	aue to t	ine cause(s)
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7		20 Name and adding	of parces :: +	completed s		00-1 (7	Dela A								
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DHMH 17 Rev 1/2001

		Registrar			Certificate	of Death		Reg. No.				
iar		I. Decedent's Name (First, Middle,					2. Date of I Month	Death Day	Year	3. Time of Death		
ca			ACY, SR.				JUL			1:25 P.		
nei		a. Facility Name (If not institution, GOODWILL MENNO	NITE HOME		GRA	own, or Location o			GARRETT	1		
		217-14-4589	5. Sex 7. Age 1	e (In yrs. last birth		Days Hours		Day, Year)	Cou	nplace (State or Forei untry) ARYLAND		
	-	Jsual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limit		
5	2	MD ALLE	GANY	CUMBE	RLAND					Yos 2□N		
Emeral Director	1	10e. Street and Number  Raltimore #1	STREET		10f. Zip C	Code .502		1	zen of What Cou	untry?		
Inora	1 Tierra	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Decede	ent of Hispanic Original Cuban, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Amer Black, White			
ž	2	1 Never Married 2 Marrie 3 ☑ Widowed 4 Divorced	Armed Forces?  d 1\( \) Yes 2 \( \) If Yes, Give Year or Dates:		1 □ Yes 2			Specify: WHITE				
lotor	Completed	15. Decedent's (Specify only highest	Education grade completed)	(	Decedent's Usual 'Give kind of work life. DO NOT use	done during most	of working	16b. Ki	ind of Business/li	ndustry		
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Boc		17. Father's Name (First, Middle, L	ast)			18. Mothe	r's Name (First, Midd	lle, Maiden	Sumame)			
TOB	0	ALBERT MACY ELIZABETH SOMM										
ľ		19a. Informant's Name/Relationshi					r or Rural Route Nun					
	_	WILLIAM H. MAC	Y, Jr./SON				SHIRE BLVI	+				
	2	20a. Method of Disposition 1 ☐ Burial 2 🎦 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	3 □Removal from State	20b. Place of C	Disposition (Name	e of	Date	20c. Lo	ocation - City or T	Town, State		
		4 Libonation 5 Library (Spe		SCARPEI	LLI CREMA		7/14/2007	CF	RESAPTOW	N, MD		
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Physician/Madical	riysicial/medical Examiner	23a. Parti. Enter the disease, or a shock or heart failure. List be the timediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 2 3 No	onplications that caused nity one cause on each lip  a. Due to (or as b. Due to (or as c. Due to (or as d. D	a consequence of Day a consequence of pregnancy 2 Fetal death time of death	22. HAPER 1302 of enter the mode  Of Va	ATORY OR AGENT AND TO THE AGENT AND THE AGEN	SERVICE, HIGHWAY, cardiac or respiratory Conce Thromb	P.A. LAVAI arrest,	LE, MD	21502 Approximate Interval Between Onset and Death / Year / / / / / / / / / / / / / / / / / / /		
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by Physician/Madical	Dy Thysicial medical Examiner	23a. Parti. Enter the disease, or a shock, or heart failure. List b Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unidering Gause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	b. Due to (or as b. Due to (or as d. Due	a consequence of a consequence of pregnancy 2 Fetal death time of death ut not resulting in the consequence of the consequence	22. HAPER 1302 of enter the mode  Of Va	ATORY OR AGENT AND TO THE AGENT AND THE AGEN	SERVICE, HIGHWAY, cardiac or respiratory Concle Throm b Blee  23e. Di 10  24a. W au pe	P.A. LAVAI arrest,  O S i S  O S i S  O S i S  O S i S  O S i S  O S i S  O S i S  O S i S  O S i S  O S i S  O S i S	23d. Date of deline Month  use contribute to Month  24b. Were autorior to code death?	21502  Approximate Interval Between Onset and Death  YEOV  /// /// // // // // // // // // // //		
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State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

completed cause of death (Item 23a) (Type, Print)

32. Comporate

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

D0058655 7/13/2007

Grantsville, Md. 21536

		in Black Indelible Ink. Ensure Al					
-	1- State of Mary	yland / Department of Health and M Certificate of Death	ental Hygiene Reg. No. 2007 23559				
Physician /Medical	Decedent's Name (First, Middle, Last)     Ricky Ro.	bert Messersmith	2. Date of Death Month Day Year 114 140 PM				
Examiner	4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death  *Hagerstown*	4c. County of Death  Washington				
Funeral Director	219-68-1182 ¹∑™ 2□F	n yrs. last birthday) Yrs.  If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Feb. 3, 1958 Maryland				
ryland how	Usual Residence of Decedent  10a. State 10b. County 10	Oc. City, Town or Location	10d. Inside City Limits				
or 28a-f sloe notified	Maryland   Washington   10e. Street and Number	Hagerstown 10f. Zip Code	1 ☐ Yes 2 ☐ No  10g. Citizen of What Country?				
s 23a o	456 Summit Ave. Apt.#1	21740	U.S.A.				
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status  1	ar in U.S.  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2♥ No Specify:	ncify Yes or No-Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:  White				
ed within 72 ho ygjene. er than "natur: t, the Medical Et.	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	16b. Kind of Business/Industry				
filed within Hygiene. Ither than ant, the Me	Elementary/Secondary (0-12) College (1-4or 5+)	Disabled	N/A				
yiailu buld be file Mental Hy arked oth atic event	17. Father's Name (First, Middle, Last)  James W. Messersmith	18. Mother's Name	(First, Middle, Maiden Surname)				
S should I and Men Is marke aumatic	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rura					
T and 2 Health em 27 Inther tra	Gerda Messersmith (Mother	20b. Place of Disposition (Name of	Hagerstown, Maryland 21740   20c. Location - City or Town, State				
Pages nent of l nrt: If ite	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery crematory or other place)	1 18, Smithsburg, Maryland				
Defaill Ole, IN permit. Pages 1 and Department of Health Important: If item 27 any injury or other it	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	J.L. Davis Funeral Home				
	23). Fart1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		Smithsburg, Maryland 21783 r respiratory arrest, Approximate Interval Between				
Physician	Immediate Cause (Final disease or condition resulting in death)	rdio Respirator	y Failure Few when				
/Medical Examiner	Due to (or as a co	onsequence of):	ing Few wles				
ed sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):  tastasis to Liver and Bones &					
be executed sician and burial-transit	resulting in death) Last  C.  Due to (or as a co		2				
ficate be of physicial is the buri	Chro	nic obstructive	Pulmonary Many /v.				
The law requires that the death certificate to the has been signed by the attending physic bage 2 should be detached for use as the bompleted by Physician/Medica	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf r 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year				
be d	Part II. Other significant conditions contributing to death but no Left Cere 4x 2 V&S	ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?				
: The law requi	Hypertens	in	24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No				
	25. Was case referred to medical examiner?  1. Type 2. 25 M3 H3 Hospital:	26. Place of Death	(Check only one)				
- हुं हुं <u>ट</u>	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at	ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certifical completely filled in by the funeral director.  Medical Certification: To Be C	2 Accident investigation	M 1 ☐ Yes 2 ☐ No					
o the Hospital lithin 24 hours o the Funeral ompletely filled	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of manual manner stated and manner stated	ny knowledge, death occurred at the time, date and place, amination and/or investigation, in my opinion, death occurr i.	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)				
To th withir To th comp	29b. Signature and title of pertifier  A Parket MU	29c. License number	7 29d. Date signed (Month, Day, Year)				
2	30. Name and address of person who completed cause of death		196R5 TOWN MID 21740				
State Begistrar	31. Date filed (Month, Day, Year) 39. Registrar's JUL 2 1 2007						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment of H rtificate of L			giene Reg. No.	07	23560
0	Dhyalai		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic	al	Catherine M. Ma			T 21. 2		July		2007	11:30 A.M
	Examin	er	4a. Facility Name (If not institution, give s 22048 Old Forge Rd			4b. City, Town, or	thsbu			y of Death shing	
- 1			5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 2	4 Hrs. 9 Date of Bird	h	9. Birth	place (State or Foreign
	Funeral Director			M 2XDF 88	Yrs.	Months Days	Hours	Min. July 5,	1919	Mar	y land
4.	P		Usual Residence of Decedent	100 600	Town or Lo	nation					10d. Inside City Limits
	anyian ehov	5	Md. Washingt	1		thsburg					1 ☐ Yes 2 ☐XNo
	the N 28a-f	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of	intry?	
	3a or		22048 01d Forge Rd			217	83		1	J.S.A	
	death	Funeral Director	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H	ispanic Orig	in? (Specify Yes or No Puerto Rican, etc.)		ce - Ameri ack, White	can Indian,
36	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Spec		White
21215-0036	hours tural,	ed by	3 XWidowed 4 ☐ Divorced  15. Decedent's Educ		16a Dece	dent's Usual Occup	ation		16b. Kind ol	Business/Ir	ndustry
5	n "na	piete	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	durina most	of working			
212	d with giene r tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	H	lomemaker				Hom	e 
밀	tal Hy	Be	17. Father's Name (First, Middle, Last)					r's Name (First, Middle,		ime)	
yla	Meni Merike Marke	ဥ	John Eshleman		101 11 25			Rhoda Marti		- Ctata 7	o Codol
Mai	d 2 sh th and 7 le n traun		19a. Informant's Name/Relationship (Typ.  John E. Martin (S	on)				r or Aural Aoute Numb . Smithsbur			p C00e/
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural; or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinating must be motified at once.		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of		Date	20c. Location		own, State
OE I	Pages ent of nt: If i		1 🔀 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			Pondsvi I		July 17,	Gree	nsbur	g,Md.
altimore, Maryland	mit. pertm porta y inju		21. Signature of Funeral Service License	- Men	non i te	Cemeter Name and Iddre	s of Facility	ral Home Sm			
8	8858		23a, Part1. Enter the disease, or complic	TWIS						rg,ma	Approximate
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that indiated events	Due to (or as a consequ	ience of):	lerosi)	3				Interval Between Onset and Death Onset And Death
Box 68760,	that the death certificate be executed ed by the attending physicien and detached for use es the burial-transit	Icai	resulting in death) Last	Due to (or as a consequence of pregnate of	ncy				23d. E	Date of delin	very
P.O. B	the death by the atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 □Fetal 4□Pregnant at time of de 9□Unknown		□Ectopic pregnancy □ Other (specify) _	<b>'</b>		٨	Month	Day Year
	law requires that the es been signed by th 2 should be detache	ρ	Part II. Other significant conditions con	tributing to death but not result from Sim	Illing in the u	inderlying cause giv	ren in Part I.	23e. Did 1	V	ntribute to 3 ☐ Pro	the cause of death?
Vital Records,	The law re ete hes bee page 2 sho	Completed						24a. Was auto perfo 1 □ Yes		prior to death?	topsy lindings available ompletion of cause of
/ita	ysician: The is certificete h director, page	Be	25. Was case referred to medical examiner?	a nestal.		0,4		of Death (Check only	one)		
of o	Physician: this certific ral director,	5	1 □ Yes 2 No	ospital: 1 Inpatient 2 I	ER/Outpatie	-	4 🔲 NU	rsing Home 5 si	dence 6 🗆 C		afy)
LO	ding I h. After funer	tion	27. Manner of Death  1 Neutral 5 Pending investigation	(Month, Day Year)	Injury	Wor	rk? Yes 2 □ I		now injury occ	41104	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location ( City or To		mber or Ru	ral Route Number,
	Hospital     24 hours     Funeral etely filled	edical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	scian. To the best of my knowner: Or the basis of examinational and manner stated.	wledge, deat tion and/or in	th occurred at the time the ti	me, date an opinion, dea	d place, and due to the th occurred at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifle	1. ~		29c. Licens	se number		29d. Date sign	ned (Manth	n, Day, Year)
			1/ Will			104	357	0	1/1	7/0	+
	Ź		1/47911	empleted cause of death (Item effegram 64	LVO .	SMIMS!	surp	non 217	e3, c	1. ha	Reen
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	sele)					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death РМ Pauline Nostadt July 7, 2007 8:30 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2210 Mt. Hebron Dr. Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Apr. 27, Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Days Hours 169 12 5821 85 Apr. 1922 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2210 Mt. Hebron Dr. 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No. White Specify. 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Mielnizek Pauline Stuczo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward A. Nostadt/husband 2210 Mt. Hebron Dr. Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Holy Sepulchre Cem. 7/13/2007 Cheltenham, PA 4 ☐ Donation 5 ☐ Other (Specify) M01442 22. Name and Address of Facility Harry H. Witzke's Family FII Inc 21. Signature of Funeral Service Licensee 4112 Old Columbia Pk. Ellicott City, MD 21043 wonin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) benevalized month Due to (or as a cons quence of): woode if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

or items 23a

'natural"

7 is marked other than "nature traumatic event, the Medical

Department of Health and Mental Hygis Important: If item 27 is marked other i

= 5

injury

any in once,

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

þ

Completed

Be

Examine

MD

physician a the burialas has been si e 2 should certificate ha irector, page 2 After this after death.

Director: / within 24 hours aft To the Funeral D completely filled in

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760

Division or Vital Records,

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autops, performed : 22 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Alesidence 6 Other (Specify) ို 1 ☐ Yes 2X No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1 X Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

45274

29d. Date signed (Month, Day, Year)

MD 21228

10/07.



State Registrar

Certification:

Medical

Cho C. Mauma GM 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

516 N Rolling Rd #301 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 0 2007

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				1 - For State Registrar/MEND#20bper/FH	_		epartment d <i>Certificate</i>	of Death	-	giene Reg. No.20	117	23562
			50	1. Decedent's Name (First, Middle, Las		ω	00/11/10410	0. D 0d	2. Date of De	ath	-	3. Time of Death
		Physici /Medi		Kevork K. Nazar	ian				July	6, 2007	Year	9:21 а м
		Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of Death		4c. County	of Death	
				Suburban Hospital	-			hesda		I		omery
	ā	Funeral Director		214-70-3345	OM 2DF	yrs. last birt	hday) If Under 1 \ Months D	Year If Under 24 Hrs. Pays Hours Min.	8. Date of Bird (Month, Da Oct. 2	y, Year)	9. Birthp Cour Syr	place (State or Foreign htry) ia
		ryland how at		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location		,		1	0d. Inside City Limits
		e Ma	Director	Maryland Montgom	nery	₩ŀ	neaton					1 ☐ Yes 2 ☑ No
		or 28	Die	10e. Street and Number			10f. Zip Co	ode		10g. Citizen of	What Cour	itry?
		ath w		2707 Henderson				0902			SA	
	Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	r in U.S.	13. Was Deceden If Yes, specify 1 \( \text{Yes} \) Yes 2 \( \text{Specify} \)	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No Rican, etc.)		e - Americ ck, White, w.White	etc.
	15-6	iin 72 h n "natu Aedical	Completed	15. Decedent's Edu (Specify only highest grad	de completed)	16a.	Decedent's Usual C (Give kind of work of life. DO NOT use i	Occupation done during most of work retired)	ing	16b. Kind of B	usiness/Ind	dustry
	212	d with giene er tha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Tr	ruck Mecha	anic		Bever	rage 1	Mechanic
	pu	al Hy l othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surnar	ne)	
	<u>Van</u>	should b ind Ment marked	2	Kevork Nazarian				Arousia	ak Nakas	shian		
	lar	2 should be and Mental Is marked or raumatic ev		19a. Informant's Name/Relationship (7)	ype. Print)	19b.	Mailing Address (S	treet and Number or Rur	al Route Numb	er, City or Town	State, Zip	Code)
		of Health of Health item 27 l		Zvart Nazarian /		270	7 Henders	son Avenue,		n, Mary	and	20902
4	Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	nemovai nom state		Disposition (Name y, crematory or othe	( 111	Date 11 Ly <del>10,</del>	20c. Location	City or To	wn, State
-	ţi	it. Partmer rtant:		4 □ Donation 5 □ Other (Specify,		ate of	Heaven (	Cemetery .	2007	Silver	Spri	ng, Maryland
1)	Bal	Depa Impo any Ir		21. Signature of Funeral Service Licens	366			ddress of Facility J. Collins				
>9				23a Part1 over the disease or comp	lications that cause the	death Don	500 Unit	rersity Blvc	or respiratory a	Silver S	prin	Approximate
0		District		23a. Part1. En er the disease, or comp shock, or eart failure. List only compediate Cause (Final	one cause on each line.	douth. Do n	or officer the filede o	r dynig, soon do sarqido	or respiratory at	1031,		Approximate Interval Between Onset and Death
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4		Examiner			V2000		6990					
101		A 5 = 8	Jer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Coronary  Due to or as a co	nsequence o	y Diseaso					More than 10 years
9		cuted id ansit	Examiner	that initiated events c. <u>Cardiodenic Shock</u>								7 Days
-	o,	e exec an an irial-tr	Exa	resulting in death) Last	Due to (or as a co	nsequence o	f):	V. J				. Days
1	68760	tificate be executed g physician and as the burial-transit	edical				- 6	6 Days				
EVORK.	P.O. Box	The law requires that the death certi te has been signed by the attending age 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ⊟Ectopic pregi 5 ⊟ Other <i>(speci</i>			1	te of delive	ery Day Year
P	σ,	s that ned b e deta	y Pr	Part II. Other significant conditions co	ontributing to death but no	ot resulting in	the underlying caus	e given in Part I.	23e. Did to	obacco use con	ribute to th	ne cause of death?
W	ord	equire en sig ould b	edk						1 🗆 1	res 2 □ No	3 ☐ Prob	ably 4 <b>S</b> Unknown
Y	Il Records,	ician: The law r certificate has be ector, page 2 sh	Completed	<del> </del>		-			24a. Was autop perfo 1∐ Yes	rmed?	Were auto prior to cor death? 1 ☐ Yes	psy findings available mpletion of cause of
2	/ita	cian: ertific	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	ne)		
£	or	physical this call dire	၉	TLI Tes ZLXINO			patient 3 DOA	Other: 4 Nursing Ho				v)
2	on C	ting F	ion:	27, Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. T	ijury	Work?	28d. Describe I	now injury occur	red	
F	isi	ttendeath death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury -	At home, far	M	1 ☐ Yes 2 ☐ No	20f Location /6	Person and Mumi		J. Courte Aliamba
NAZARIAN	Division or Vital	tal or A s after al Direc ed in by	Certification:	4 ☐ Homicide determined	building, etc. (S	Specify)	m, street, factory, o	liice	City or Tov	vn, State)	er or Hura	il Route Number,
2		To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exam	ysician: To the best of my iner: On the basis of exa and manner stated.	amination and	death occurred at 1/or investigation, in	the time, date and place, my opinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as si and due to	ated, the cause(s)
		To ti To ti Comp	Ň	29b. Signature and title of certifier	0 . / /			cense number		29d. Date signe		• •
		$\cap$		Jun a. h	Lughak		D41	1311		Ju	1у б,	, 2007
		1		30. Name and address of person who c Yuri A. Deychak,				re, #200, Be	thesda,	MD 208	17	
	П	Sta Registr		31. Date filed (Month, Day, Year) <b>JUL 0 9</b> 200	32 Registrar's S	Signature	parte					

			For State Registrar	State of Mai	ryland /		artment of H rtificate of I		ınd Mer		iene eg. No.	2007	23561	
	Physicia	an	1. Decedent's Name (First, Middle, Li							Date of Deat Month	Day	Year	3. Time of Death	
	/Medic	al -	Sarah M.	Nolan			4b. City, Town, or	L postion of		ily 4,	200	Ounty of Death	11:34 A M	
)	Examin	er	4a. Facility Name (If not institution, gi Brighton Gardens		an		Rocky		Dealli		40.0	Montgo	merv	
	Funeral Director		5. Social Security Number 6. 355-12-1986		(In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth Month, Day,		9. Birth	place (State or Foreign	
pue	A		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits	
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th the	or 28a e noti	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	en of What Cou	ntry?	
ath wi	23a ust b	ral	5550 Tuckerman L					852				.S.A.		
is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ver in U.S.		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2🖾 No	ispanic Orig in, Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- in, etc.)		4. Race - Americ Black, White, Specify: W		
<b>5</b> 6	'natur dical I	Completed	15. Decedent's E (Specify only highest g.	ducation rade completed)	lucation 16a. Dece de completed) (Give		dent's Usual Occup kind of work done o DO NOT use retired	ation during most	of working		16b. Kind	d of Business/In	dustry	
within	ene. than '	Idmo	Elementary/Secondary (0-12)	College (1-4or 5+)			DO NOT use retired Teacher	1)			Priv	ate Sch	001	
Filed A	Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, Las	· · · · · · · · · · · · · · · · · · ·				18. Mother	r's Name <i>(Fi</i>					
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seho	and had is ma		19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailir	ng Address (Street	and Numbe	er or Rural Ro	oute Number	City or	Town, State, Zij	Code)	
2 's	tealth	0.0	James Nolan/Son 20a. Method of Disposition				Oliver Av	re. An	nanda. Date			ia 2200 ation - City or To		
Pages :	tment craye		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	ify)	Metro	ptery, crei poli nator	matory or other plac Ltan	- !	July ! 2007	5, A	1exa	andria,	Virginia	
ם פ	Depar Impor any Ir		21. Signature of funeral Service Lice	120/21		- 1							20007	
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Pneumonia											
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pat	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a			ia							
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or continue	ing ph	Med	IF FEMALE:											
DIVISION OF VICE DECOMES, F.O. BOX	been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery  Month Day			
o that	gned b	by Pl	Part II. Other significant conditions	contributing to death but	not resulting	g in the u	nderlying cause give	en in Part I.		23e. Did tob	acco us	e contribute to t	the cause of death?	
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	has be	Completed					· · · · ·			24a. Was a autops perform	V	24b. Were auto prior to co death?	opsy findings available ompletion of cause of	
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Velcia	s certi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	t 2∏ER/	Outpatier	nt 3 DOA Oth		of Death (Co			□Other (Speci	(fv)	
5 6	ter thi		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	281	o. Time o				Describe ho			97	
	eath.	atio	2 ☐ Accident investigation	on			M 1 🗆	Yes 2□N						
Talout Talout	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	4 Homicide determine	building, etc.	(Specify)					City or Town	n, State)		al Route Number,	
the Hoen	tin 24 hou	Medical	(Check only 2 Medical Ex-	Physician: To the best of aminer: On the basis of and manner state	examination		vestigation, in my o	opinion, dea		at the time, d	ate and	place, and due	to the cause(s)	
F	To Son	2	29b. Signature and title of certifier	RT	0		29c. Licens D196					signed (Month)		
6	3		30. Name and address of person wh				Print)		: + h					
	-Ct-	to.	Raman Tuli, M.D.	32 egistrar	's Signature			UZ Gai	ııners	burg,	MD 2	200/0		
	Sta Registr		31. Date filed (Morth, Pay, Year)	2007 Deserve	, K	A	we							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day \_\_ Month **Physician** Zoriada Nieves 16, 2007 July 8:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N.M.S. Health Care Center *Hagerstown* Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 51 Director 354-50-0551 Jan. 9, 1956 Illinois Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or Items 23a or 28a-f shovedical Examiner must be notifled at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 should be filed within 72 hours after death with I and Mental Hygiene.
Is marked other than "natural", or Items 23a or 2 14014 Marsh Pike 21742 Funeral U.S.A.12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 √ Yes 2 No Specify: þ Puerto Rican Specify: Puerto Rican ₩ Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Hospital other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ines Nieves Justina Zayas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Health Item 27 Jose Nieves (Brother) 5595 Ray Lane O'oltewah, Tennessee 37363 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. July 18, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Smithsburg Crematory Smithsburg, Maryland 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO14/4 12525 Bradbury Ave. Smithsburg, Maryland 21783 29vis Lee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Repinions 00 Inne か /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 9 2 1 No 3 Probably 4 Unknown cate has been si page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 2 4 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 La Nersing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 10 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28c. Injury at Work? After Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cau ms D 18019 16 200) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTOWN MD 21740

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

VASANT DATTAMD



340

MILLST

07-05401 Maria Villeda

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 23565

		I- For State		Cer	tificate of	Death					Reg. No.	discount facility	21 62001
Physicia edical Exami	in/	1. Decedent's Name (First, Mid	<sup>dle,Last)</sup> <b>Maria</b> L VILLED	Isabel Vill A OSORI	Leda-Osor <del>O</del>	rio				Date of Dea Month July 14, 2	Day 2007	Year	3. Time of Death 2200 hrs
		4a. Facility Name (if not institut Prince George's Hos		umber)		4b. City, Tow Cheverl		ocation of	1		Pr	County of De rince Geor	rge's
Funeral Director		5. Social Security Number un	6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs	If Under 1 Months		If Under Hours	24Hrs. Min.		irth(MM/D	For	Birthplace (State or reign Country) Guatema 1 a
	H	Usual Residence of Decedent	I W ZA F	2.9	113					07 2	0 17	<del>//</del>	Odd Date Land
ŕ	ŀ	10a. State 10b. Count	у	10c. City,	Town or Locat	ion							10d. Inside City Limits
Maryland 28a-f show any d at once	5	Maryland Princ	ce George'	s Gle	n Arde						10 0'''	. 534H -1 G	1 X Yes 2 No
daryl 28a-1 1 at o	Director	10e. Street and Number				10f. Zip Co	ode				Tug. Citiz	en of What C	Journa y r
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eath with the liems 23a or	era	11. Marital Status	A see and	ecedent Ever in U. Forces?		as Decedent (es, specify (					lo-	<ol><li>Race - Ar White, etc</li></ol>	merican Indian, Black, c.
0036 within 72 hours after death with the Maryland sjene her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Funeral		1 Yes	2 X No								11	lianania
after al", c	ò		Divorced If Yes, Give Y								eca [	Specify: II	lispanic
nours		15. Decedent's Education (S			16a. Deceder during n	nt's Usual Od nost of workir	cupations	on (Give k DO NOT i	ana of wo use retire	ed)	IOD. N	and of busine	:SS/Industry
6 172 h	et	Elementary/Secondary (0-1)	2) College	(1-4 or 5+)	Chil.	i Care					05/7	n Home	
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Hygh oth		17. Father's Name (First, Midd					- 1 '					ourname,	
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Juan Antonio  19a. Informant's Name/Relatio			10h Mailir	a Address	Street	and Num	ta Li	uz Osc	mber Ci	ty or Town. S	State, Zip Code)
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Baltimore, MD 21215-0036 Deparit. Pages I and 2 should be filed within 72 hours after Department of Health and Meutal Hygiene. Important: If tiem 77 is marked other than "natural", injury or other traumatic event, the Medical Examinar.		Wilber O. Vii	Lieda - Bi	other	Place of Dispo				Lan	Date .	20c. l	Location - Cit	y or Town, State
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altimore, mit. Pages 1 ar partment of Her portant: If ite ury or other tr		4 Donation 5 Other	Specify:		nicipa <u>l</u>					23-200			o, Guate <u>mala</u>
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<b>യ</b> ഉള <b>്</b>		" / Maria	Mintes	17013	375 G	asch's	Fu	nera.	1 Ho	me, P.	Α	Hyattsv	rille, MD 207
Physician		23a. Part I. Enter the disease, failure. List only one cau	or complications that ise on each line.	t caused the death	. Do not enter	the mode of	dying,	such as ca	ardiac or	respiratory a	arrest, sno	ock, or near	Between Onset and
M. dical Examiner		Immediate Cause (Final disea		subarachno:	id and i	ntravent	ric	ular h	err	hage			Death
-xaiiiiiei		or condition resulting in death	Due to (or a	s a consequence of									
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	Examiner	if any, leading to immediate cause. Enter Underlying Cau	se	s a consequence o	); ;								
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Box 68 e death certi the attendin ed for use as	sic	1 Yes 2 No 9	Lieksour	known	eath 5	Other (Speci	(y) _						
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certivithin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be deached for use a	Physicia	Part II. Other significant cor			resulting in the	underlying o	ause g	iven in Pa	art I.	23e. Di	d tobacco	use contribu	ite to the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requirer as after death.  al Director. After this certificate has been siled in by the funeral director, page 2 should it.	Be	25. Was case referred to med examiner?						of Death	<del>`</del>				
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ing Ph After t		27. Manner of Death	28a. D (M	ate of Injury onth, Day,Year)	28b. Time o	f Injury 2	-	ry at Worl	_ I	28d. Descri	be how inj	jury occurred	
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VISI or Att fter de oirect in by	ertification:		Could not be 28e. F	Place of Injury - At I	home, farm, sti	eet, factory,	office b	ouilding, e	tc.		n (Street and State)	and Number	or Rural Route Number, C
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the:	F	4 Homicide	letermined (Spec										
Hosp 24 ho Func tely f	2 S	29a. Certifier 1 Certifyin	g Physician: To the	best of my knowle	dge, death occ	curred at the	time, d	ate and pl	ace, and	due to the c	ause(s) a	nd manner as	s stated.
o the ithin o the	Medical	one) 2 ✓ Medical I	Examiner:On the bar and mann	sis of examination er stated.	and/or investig					it the time, a			
	ĮĔ	29b. Signature and title of ce	rtifier			29c.		e number	r		- 1		(Month, Day,Year)
3		m	his.	MJD			O.C.	M.E.			Jul	ly 15, 200	7
Bj		30. Name and address of per	son who completed	cause of death (Ite	m 23a)								
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	State		ear) 32	. Registrar's Sig	fure								
Regi	stra	L	Color	11. 11.	7.5gH-2977								
DRIME TO KEV TO	ZUU 1		DOME		ORIGIN	AL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician**  $\underline{A}^{\,\mathsf{M}}$ O'Neill July 8 2007 4:00 Francis Barry /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6366 Albers Drive Mt. Airy Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 22, 1917 Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 1 M M 2 □ F 213-03-2764 89 Director Maryland Usual Residence of Decedent the Maryland 10c City Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Directo Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or? ral", or items 23a Examiner must b 6366 Albers Drive 21771 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☒ No White Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever Richard O'Neill Mary Cadigan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry O'Neill / Son Mt. Airy, Maryland 21771 4001 Windsong Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State July 11, 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery Mt. Airy, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sign were of Funeral Service Licenses 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass of Figure 1) Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Hllnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s autopsy performe the Hospital or Attending Physician; after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 2NO 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours afta

To the Funeral Di

completely filled in 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100059943 9,2007

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records,

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ve. 5 mple 307

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. Angel

31. Date filed (Month, Day,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 10:10 A<sup>M</sup> 2007 Spurrier Thomas 0gle Ju<sub>1</sub>y 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 201 Park Avenue Carrol1 Mt. Airy If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1⊠M 2□F 215-42-8312 61 Nov. 16, 1945 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 201 Park Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🖾 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Noise Control Director County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas A. Ogle Audrey Spurrier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Lamborn / Wife 124 S. Oak Cliff Court Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 10, 2007 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at

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permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important; If Item 27 Is marked other i any Injury or other traumatic event, tt

traumatic event, the

Director

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72 hours after

Baltimore, Maryland 21215-0036

burial-trar physician funeral

requires that the death certificate be executed ed by the a detached f signed t been signated After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Division or Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

	23a. Part1. Enter the disease, or company shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not enter the m	ode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between				
	Immediate Cause (Final disease or condition	. Cirrho	515 64	fliver			Onset and Death				
Ical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	tany, leading to immediate ause. Enter Underlying lause. Disease or injury had initiated events									
iysician/imedi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										
ea by Pr	Part II. Other significant conditions o	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacc		to the cause of death? Probably 4 □Unknown				
Completi					24a. Was an autopsy performed	prior to death?	autopsy findings available completion of cause of s 20 No				
g	25. Was case referred to medical examiner?	11-3-14-1			ath (Check only one)						
0	1 ☐ Yes 2 No	Hospital: 1   Inpatient 2			Home 5 ₺ Residence	6 □Other (Sp	ecify)				
ation;	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred					
ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined					Rural Route Number,					
dical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurrent ation and/or investigati	ed at the time, date and place ion, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and do	as stated. ue to the cause(s)				
ĕ	29b. Signature and title of certifier	0 -	. 2	29c. License number	29d. 1	Date signed (Mo)	th, Day, Year)				

DHMH 17 Rev 1/2001

Registrar

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filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

the Medical Examiner must be

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within 24 hours after deat To the Funaral Director: filled in by 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Madipal Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16428 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 15 Casper E. Cline III M.D. 300 West 9th Street, Frederick, Maryland 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2007 Course State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** JÜLY **JEANETTE** LEE **PFLUGER** 4 7:13 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPRING MONTGOMERY #403 15107 INTERLACHEN DRIVE If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 M 2 X F 577-22-3390 101 Director June 6 1906 Washington, D.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Silver Spring 1 ☐ Yes 2 No Md. Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with t Hygiene. ither than "natural", or Ite⊞s 23a or 2 20906 United States 15107 Interlachen Drive #403 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 0 Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If item 27 is marked other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sallie Frances Dillard Wise ဂ္ Worthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trauonce. 111 Encore Court, Centreville, Md. Carolyn J. Dent / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7/9/07 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses 20882 Box 5038, Laytonsville, Mđ. P. O. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Cardiovascular Disease 20 Years /Medical Due to (or as a consequence of): Examiner Hypertension 40 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform spital or Attending Physician: Thours after death.

Ineral Director: After this certificate yfilled in by the funeral director, pa 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 9 2007

Samuel G. Maller, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D 0050612

3305 N. Leisure World, Silver Spring, Md.

July 5, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 18, Day 2007 Year July **Physician** 5:20 pm м Rhoderick Mahlon Edward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner | Freuer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Ianuary 2, Frederick Frederick Homewood @ Crumland Farms 9. Birthplace (State or Foreign 1915 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 12 M 2□F 92 Yrs. 214-10-3166 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Oa. State 10b. County Maryland Frederick Frederick 1 X Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7341 Willow Road, # 40 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Installer Federal Government 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rhoderick Earl Maurice Lillian Anita Milyard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy G. Rhoderick, Wife 7341 Willow Rd, # 40, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Jul 21, 2007 Frederick, Maryland 4 ☐Donatign 5 ☐ Other (Specify) 21. Signature of Fugeral Service License 22 Keeney & Bastord P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland 21701 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear natiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) souration wh Due to (or as a consequence of): me S - uential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, o Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Known to physician and mahlon Rhadevick

**Funeral** 

Director

permit Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene.
Important: if item 27 is marked other than "naturel", or itema 23a or 28a-f ehow any in ury or other treumatic event. The Madical Examiner must be notified at once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

(7

29a, Certifier

29b. Signature and title of certifier

31. Date liled (Month, Day, Year) JUL 2 3 2007

A. Austin Pearre, Jr, M.D., 300 West Ninth Street, Frederick, Maryland 21701

29112

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

009689

29d. Date signed (Month, Day, Year)

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07-05199 Gary Patrick Reilly

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Physicia	ın/	legistrar 1. Decedent's Name (First, Middle,Last)		Date of Death     Month Da		3. Time of Death 2201 hrs
ledical Exami ?		Gary Patrick Reilly  4a. Facility Name (if not institution, give street and number)  4b. City,	Town, or Location of Death	July 6, 2007	4c. County of Death	
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Funeral Director		or decidir decidir, rumber	der 1 Year   If Under 24Hrs. ths   Days   Hours   Min.		1970 9. Bir 1970 Co	hplace (State or Maryland untry)
any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		<del></del> .		10d. Inside City Limits
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th the Maryland 23a or 28a-f show notified at once.	Dire	10e. Street and Number 19482 Brassie Place	ip Code 20886	10g.	Citizen of What Cou	ntry?
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 XXBurial 2 Cremation 3 Removal from State Gate of Heave	en Cemetery J.	uly 12, 2007	Silver Sor	ing, Maryland
Baltir permit. I Departme Importar injury or		21. Signature of Funeral Service Licensee 22. Name at	d Address of Facility			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod	niversity Blv e of dying, such as cardiac o	d, W., Si	lver Spri	Approximate Interval
Physician Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Asphyxia by hanging				Between Onset and Death
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ox 6 ath cer attendi	Physician/	1 Yes 2 No 9 Unknown g Unknown	pecify)			A.
D. B. t the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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tendir eath. tor: A	ation	1 Natural 5 Pending Jul 6, 2007 0000 hrs 2 Accident Investigation	1 Yes 2 No			0.1
Divis nrrA satero	Certification:	Suicide 6 Could not be determined (Secolid) Cingle Family	ory, office building, etc.	or Town, Sta		tural Route Number, City  Village, Md.
Diwision of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after ceath.  To the Finneral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burial	ical Ce	29a. Certifier (Check only one)  29b. Certifying Physician: To the best of my knowledge, death occurred at one)  20c. Certifying Physician: To the best of my knowledge, death occurred at one)	the time, date and place, and my opinion, death occurred	d due to the cause(	s) and manner as sta	ated.
To t With To t	Medical	and manner stated.	29c. License number		29d. Date signed (M	
6		Calract V	O.C.M.E.		July 7, 2007	
		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD 2	1201		
	tate	31. Date filed (Merry DayYea) 2007 3 Registrar's Signature	,			
Regis	ાલકો	The state of the s		OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 1,30 per doc 2876, 2-1-08 yr.

State of Maryland Popularinent of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lena Elizabeth Roberto July 4, 2007 Lena Helen Roberto **Physician** 9:30 p M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital <u>Bethesda</u> If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Feb. 17 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1919 Months Days Hours 1 ☐ M 2√2 F 88 Washington, DC 577-18-5987 Yrs Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show citem 27 is marked other than "natural", or items 23a or 28a-f show hen tranmatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland | Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20851 1302 Crawford Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian. Black, White, etc. 1 Never Married 2 Married <sub>Specify:</sub> White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Elizabeth Tenley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Department of Health a Important: If item 27 is any injury or other trai Patricia Watson/Niece 1230 Allison Drive, Rockville, MD 20851 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Gate of Heaven 7-11-2007 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune of Service License 22. Name and Address of Facility Simple Tribute, 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Usering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and for use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by Records, Dementia 2☐No 3☐ Probably 4☐Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Stage 4 Sacral Decubitus Ulcer autopsy performed? /es 20 No The Malnutrition certificate 1 Yes or Vital Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death Date of Injury
(Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter Division Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident after death completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063195 July 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 9 2007

Stephen David Wilks, M.D., 9901 Medical Center Drive, Rockville, MD 20852

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician P M KATHRYN ELIZABETH ROSA July 05 2007 7:50 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Casey House - Montgomery Hospice Rockville 8. Date of Birth (Month, Day, Year If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 X F 202-14-9447 83 May 10, 1924 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Silver Spring Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 U.S.A. 3 Finsbury Park Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 Is marked other than "natural", or ite 1 ☐ Never Married 2X Married <sub>Specify:</sub> White 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Services Registered Nurse 3 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hedish Elizabeth Francis Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and Department of Health Important: If item 27 any injury or other troonce. Eric C. Rosa/Son 85 West Wistaria Avenue, Arcadia, CA 91007 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Crematory 07/09/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. Na 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Stage Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cursoonence of Examiner Physician; The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No Pulmonary Hypertension 24a. Was an certificate has autopsy performed? 1∐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) Hospice 1 ☐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. the within 2 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier è 00064615 July 7, 2007 nemene 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski, MD, 6001 Muncaster Mill Road, Rockville, MD 20855 egistrar's Signature 31. Date filed (Month, Day, Year) State

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Kevin Christoph		1- For State Registrar	e of Maryland / [	Department of Certificate of		d Menta		Reg. No.	
Physici Medical Exami		1. Decedent's Name (First, Middle,L Kevin Christor					2. Date of Dea Month	Day Year	3. Time of Death 2308 hrs
ř		4a. Facility Name (if not institution, g			4b. City, Town, or	Location of	June 30,	4c. County of De	
		Walnut Creek Rd & She			Huntingtow			Calvert	
Funeral Director				n yrs. last birthday)	If Under 1 Year Months Day		24Hrs. 8. Date of Bi Min.	) IFo	Birthplace (State or reign
Bilector		219–33–0049 <sup>1</sup> Usual Residence of Decedent	X M 2 F 17	Yrs			Oct.	25, 1989	Country) Maryland
any	-17 Fm	10a. State 10b. County	100	c. City, Town or Locat	ion				10d. Inside City Limits
faryland 28a-f show 1 at once.	ō		County	Sunderla		_	1.0		1 Yes 2 X No
Mary r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
with the Maryland ms 23a or 28a-f sho be notified at once.	aD	6015 Gordon Dri	VE 12. Was Decedent Eve	erin U.S. I 13 Wa	20689		1? ( Specify Yes or No	U.S.A.	nerican Indian, Black,
death v r item	Funeral	1 X Never Married 2 Marrie	A	. If Y			Puerto Rican, etc.)	White, etc	
after ral", o	by F		ed If Yes, Give Year	1 🗌	Yes 2 X No			Specify:	White
2 hours "natu	ted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade comple College (1-4 or 5+)		nt's Usual Occupa lost of working life			16b. Kind of Busine	ss/Industry
5-0036 led within 72 Hygiene. other than '	Completed	12	ounogo (Tronos)	Stu	dent			Colleg	e
15-0 iled w Hygie d other		17. Father's Name (First, Middle, La	•	l.			Name (First, Middle,	,	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	To Be	Steven A. Stav  19a. Informant's Name/Relationship		19b. Mailin	n Address (Stree		n A. Whea	.tley mber, City or Town, Si	rate Zin Code)
MD d 2 shot lth and lth and ls randlar ls randlar nation	-	Steven A. Stave					•	d, Marylan	
re, re, re, re, re, re, re, re, re, re,		20a. Method of Disposition  1 X Burial 2 Cremation	Removal from State	20b. Place of Dispos		metery,	July 5,	20c. Location - City	
Baltimore, permit. Pages I an Department of Hea Important: If iter		4 Donation 5 Other Speci	_	Chesapeak	e High.	Mem.	2007		ublic, MD
Baltimore, MD 21215-C permit. Pages I and 2 should'be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the I		21. Signature of Fundamental W	insee						lvert, P.A.
Physician		23a. Part I. Enter the disease, or cor							s, MD 20736 Approximate Interval
/Medical :aminer	3 1	failure. List only one cause on Immediate Cause (Final disease	<sup>each line.</sup> <sub>a.</sub> Head and Neck Inj	uries		N°.			Between Onset and Death
.aiiiiiei		or condition resulting in death)	Due to (or as a conseque	ence of):					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	ence of):		_			
	Examine	(Disease or injury that initiated	Due to (or as a conseque	ence of):					
ecuted 1 and - transit		events resulting in death) Last	d						
60, nte be exe hysician a	dice	UNPENDED	AMENDED						
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed eath. for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		etal death 3	Ectonic n	regnancy	23d. Date of deli	very Day Year
Box 61 c death cert the attendir ed for use a	sicia	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time	o of dooth	her (Specify)			Monus	Day Teal
D.O. BC that the des ned by the a detached fo	Phy	Part II. Other significant condition	9 Olikilowii	it not resulting in the i	Inderlying cause	niven in Part	I 23e Did t	obacco use contribute	to the cause of death?
S, P.O. nires that the signed by d be detach	ē	,	oonang to down of	ar not roodining in the	and anything coulder	giroiriiri		es 2 V No 3 F	
of Vital Records,  g Physician: The law require.  the this certificate has been sineral director, page 2 should h	Completed	Î					24a. Was		autopsy findings available to completion of cause of
Reco The lav icate has	ошо							ormed? death	i?
Vital Re ysician: The his certificate director, paga	Bec	25. Was case referred to medical examiner?			26.Place		heck only one)		
f Vil Physic er this	의	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpatient		Other4 1	Nursing Home 5	Residence 6 🗸 O	ther: Scene
on of Anding Ph th. r: After ti	Certification:	1 Natural 5 Pending	J28a. Date of Injury (Month Day Year) Jun 30, 2007	2303 hrs		Yes 2 ✔ N	Passenner	how injury occurred auto fixed object	collision
	ificat	2 Accident Investigation 3 Suicide 6 Could not	28e Place of Injury	- At home, farm, stre	et, factory, office t	ouilding, etc.			Rural Route Number, City
E 8 5	Ser	4 Homicide determin		Street			or Town, Walnut Cree	State) k Rd & Shelley's Cr	ossing, Huntingtown , M
Divis To the Hospital or Alwithin 24 hours after of To the Funeral Direct completely filled in by			cian: To the best of my kn er:On the basis of examina						
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (	
		Lande	en mos		O.C.	M.E.		July 1, 2007	
7	-	30. Name and address of person wh	o completed cause of death	,					
3		Tasha Greenberg MD.	Assistant Medical E		Penn Street,	Baltimore	e, MD 21201		
St Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 5 2007	32. Registrar's S	Soule Soule	•				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 Year **Physician** July 4 8:06 P M Ellen Sanborn Bernyce /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01-14-1934 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🕅 F 73 North Dakota Director 502-30-5041 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 XNo Director Dunkirk MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or be 20754 USA 3528 King Drive "natural", or items 23a death v Funeral 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 Types 2 No
If Yes, Give
Year or Dates:1955-56 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. ð 3 Nidowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Budget Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Kinnischtzke Elfrieda Braun ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health an.
Important: if item 27 is my any injury or other 2:
once. 9505 Howes Road, Dunkirk, MD Lauren K. Schroeder, daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 07-10-2007 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Illiam 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic arcinoma /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months?
1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 No Division or Vital 25. Was case referred medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pin 24 hours after death. 28c. Injury at Work? After t (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)0027189 mouson 2007

State Registrar

31. Date filed (Month, Day, Year) JUL

ZAHIR YOUSAF, MD. 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2417 Solomons Island Rd. Huntington 32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 4, 2007 **Physician** 3:28 P.M SATIN Leo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 7, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Newryyork 1 <del>□</del> M 2 □ F 89 098-07-5592 Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 XNo Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20906 U.S.A. 3310 N. Leisure World Blvd. # 419 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No WWII If Yes, Give Year or Date US Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
State of New York 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Wolhandler Israel Satin ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10205 Holly Hill Pl., Potomac, MD 20854 19a. Informant's Name/Relationship (Type. Print) Andrew Satin / son item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town. State permit. Pages 1
Department of H
Important: If iten
any Injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Montefiore Cem. July 8,2007 Farmingdale, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pancreatic Cancer Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 □ Yes 2 □ No. 9 Dunknown signed by d be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2□ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P Hospice this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Injury 5 Pending investigation within 24 hours after com.

To the Funeral Director: Aft

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 4, 2007 D0064615 CW3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Dr., #100, Rockville, Maryland

State Registrar

Genevieve Anne Wroblewski

0 9

31. Date filed (Month, Day, Year)

JUL

istrar's Signature

07-0512	27
Mary S.	Schoolman

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	n waryland / L	Certifica			intai riygi	Reg	. No. 2	00	7 2357
Physicia	an/	Decedent's Name (First, Middle,Last)						Date of Death	Day Year		3. Time of Death
Medical Exami	ner	Mary Sackl		lman	45 03	. Tour orlander	J	uly 4, 2007	4c. County o	f Daath	2030 hrs
		4a. Facility Name (if not institution, give 4701 Willard Avenue Apt. 1	· · · · · · · · · · · · · · · · · · ·			y, Town, or Location evy Chase	1 of Death		Montgon		
Funeral		Social Security Number 6. Sex	7. Age (I	n yrs. last birth	day) If U	Inder 1 Year If Un	der 24Hrs. 8	. Date of Birth	(MM/DD/YYYY)		place (State or
Director		064-12-6152	M 2x F 99	9	Yrs. Mo	nths Days Hou		Sept.	16, 19 <b>07</b>	Foreign Coun	ntry) New_York
		Usual Residence of Decedent						ССРСС			
w any		10a. State 10b. County		c. City, Town o							0d. Inside City Limits  1 X Yes 2 No
daryland 28a-f show 1 at once.	į	Maryland Montgome:	СУ	Chevy		Zip Code		1400	Cities of Min		
th the Maryland 23a or 28a-f she notified at once	Director								. Citizen of Wh	at Counti	<b>y</b> f
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once		4701 Willard Ave	12. Was Decedent Ev	er in U.S.		0815 edent of Hispanic O	rigin? ( Specif		J.S.A.	- America	n Indian, Black,
death v	Funeral	1 Never Married 2 Married	Armed Forces?  1 Yes 2 2			ecify Cuban, Mexica			White		_ 4 - 400
after o	by F	3 X Widowed 4 Divorced	f Yes, Give Year or Dates:		1 Yes	2 X No specif	y:	14	Specify:	Whi	te
hours	pa	15. Decedent's Education (Specify onl		dı		ual Occupation (Given working life, DO NO			l6b. Kind of Bus	siness/Inc	dustry
36 nin 72 s. than "dical	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		D-m-2	. C	0.00		Theat		1
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medical	E O	17. Father's Name (First, Middle, Last)			riivat	e Secreta 18.Moth		rst, Middle, Ma	iden Surname)		L .
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Solomen Sackle	er			Le	na				
	٩	19a. Informant's Name/Relationship (Ty				ess (Street and Nu					
e, MD I and 2 sho Health and item 27 is		Toni K. Allen  20a. Method of Disposition	/ Daughte	20h Place of	Disposition	entbranch Name of cemetery,		thesda,	Maryla 20c. Location -	and 2	20816
늘으矢드리		1 Burial 2 XX Cremation 3	Removal from State	cremato	ry or other pla	ice)		-		•	•
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	00	Nation	nal Cr	ematory	JU1y	9,07	Falls (	Churc	ch, Va.
Ba perm Depa Impo		William William Strains			5130	Misconsi	" Josej	ph Gawl	er's So	ons,	Inc. O.C. 20016
Physician		23a. Part I. Enter the disease, or compli	etions that caused the	e death. Do not	enter the mo	de of dying, such as	cardiac or re	spiratory arres	t, shock, or hea	irt I	Approximate Interval
/Medical		failure. List only one cause on each	n line. lypertensive Athe	erosclerotic	Cardiovas	cular Disease					Between Onset and Death
Adminier			ue to (or as a consequ	ence of):						$\neg$	
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequ	ence of):					- 8	$\rightarrow$	
0	Examiner	cause. Enter Underlying Cause									
Ø 2 [ig]	Exa	events resulting in death) Last	ue to (or as a consequ	ence of):						Ī	
760, cate be executed physician and he burial - transi	ical	UNPENDED d.	AMENDED					<del>-</del> .			
760, icate be physical the burn	Medical	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date of	delivery	
Ox 687 sath certific	sician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at tim	2	Fetal dea		oic pregnancy	,	Month	Da	y Year
Box 68 death certifi the attending of for use as p	ysic	1 Yes 2 No 9 Unknown	9 Unknown	ie or death 5	Other (S	Specify)					
that the d	/ Phy	Part II. Other significant conditions	contributing to death be	ut not resulting	in the underly	ing cause given in !	Part I.	23e. Did tob	acco use contri	bute to th	e cause of death?
ires that the signed by lbe detacl	d by							1 Yes	2 V No 3	Proba	bly 4 Unknown
Division of Vital Records, P tal or Attending Physician: The law requires tra after death.  al Director: After this certificate has been sign led in by the funeral director, page 2 should be c	Completed							24a. Was ar autopsy			psy findings available mpletion of cause of
Recc The lav	E							perform 1 <b>V</b> Yes 2		eath?	2 No
tal Rection: The certificate ector, page	BeC	25. Was case referred to medical examiner?				26.Place of Deat	h (Check only	one)			
F Vit	5	1 🗸 Yes 2 No	ospital: 1 Inpatient		tpatient 3	DOA Other	Nursing H		esidence 6		Scene
n of Iding P. Is. After Funera	ü	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year	) 286. 1	ime of Injury	28c. Injury at Wo	_	d. Describe ho	w injury occurre	∌d	
isio Atter Atter rector by th	icati	2 Accident Investigatio	28e Place of Injun	v - At home, far	m street fact	ory, office building,		f Location (St	reet and Number	er or Rura	Route Number, City
Division of Vital Rec pital or Attending Physician: The ours after death. eral Director: After this certificate filled in by the funeral director, page	Certification:	3 Suicide 6 Could not b determined	e (Specify)	,	.,,	,,		or Town, Sta			
Hospi 24 hou Func		29a. Certifier 1 Certifying Physicia	n: To the best of my ki								
Division of Vital Records, P.O. Box 687. To the Inspiral or Attending Physician: The law requires that the death certificating the fours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the funeral director.	Medical	one) 2 Medical Examiner:	On the basis of examin and manner stated.	ation and/or in	vestigation, in	my opinion, death of	occurred at the	e time, date ar	nd place, and d	ue to the	cause(s)
7 0	ž	29b. Signature and title of certifier	0 . 1			29c. License numbe	er	i	29d. Date signe		h, Day, Year)
		Joishe Je	ejhio			O.C.M.E.			July 5, 200	/	
		30. Name and address of person who con Tasha Greenberg MD. A	ompleted cause of deal ssistant Medical I		111 Pen	n Street, Baltim	ore, MD 2	1201			
St	ate		32 Pagistrar's		A 4	: District Baltim	, mb 2				
Regist		31. Date filed (Month, Day, Year) 20	Ul Blokur	15.	Good	9					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month TICHAEL /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIN If Under 1 Year BALTIMOTE 10VE BALTIMOR ATTAIRS HOST 8. Date of Birth 1/28/1949 Social Security 9. Birthplace (State or Foreign **Funeral** 915. la Days Months Hours Min 1 M 2 □ F NewYork 099-36-3360 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Modical Examiner must be notified at Director MD Harford Churchville 1 ☐Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21028 3123 Churchville Road U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give 1967-70 Year or Dates 1967-70 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Printer Printing other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mantal by Importent: if item 27 is marked oth any injury or other traumatic event ones. 18. Mother's Name (First, Middle, Maiden Sumame) Be Rudolph Valentino, Sr. Grace Impirel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Angela Valentino (Daughter) 21028 3123 Churchville Rd. Churchville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co. 7/20/07 West Chester, PA 21. Signature of Funeral Service Licenses Tarring-Cargo Funeral Home, p.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certiticate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown been si 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has b lirector, page 2 s autopsy performed? 2[1No 1 Yes 2 🗆 No 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director 26. Place of Death | Check only one) Hospital: Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Medical Certification; To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Atter s after do... rel Director: Atr 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 - Homicide within 24 hours a To the Funarel C completely tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certilies 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and add ess of person who completed cause 325 Registrar's Signature State S. California Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylar		artment of H rtificate of I		lental Hygie Reg.	6001	23579
36	- 2	20	Decedent's Name (First, Middle,	Last)					2. Date of Death		3. Time of Death
	Physici			Elizabe	et h	Ver	nier		July 5	Day Year 2007	5:50 P M
	/Medio		4a. Facility Name (If not institution,					r Location of Death	1	4c. County of Death	
			Calvert County	Nursing (	Center		Prince	Frederic	ck	Calvert	
100	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
164	Director	ŝ	579-38-1403	1 L M 2 L F	80	Yrs.			09-15-19	26 Wash	., D.C.
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho ed at	ō		LE			<i>α</i> Ι	les Donals			1 □Yes 2 X No
	the N 28a- notifi	Director	MD Calve  10e. Street and Number	rt			Chesapea	ke Beach	10g.	Citizen of What Cou	intry?
	3a or	Ö	4555 Willows R	oad			207	32		USA	,
	ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	I.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	
9	after or ite	₫	1 ☐ Never Married 2X Marrie	Armed Formed To 1 ☐ Yes If Yes, Gi	2 🛛 No		If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		Hican, etc.)	Black, White,	, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or D	ates:		T⊟ Tes ZANO	эреспу.		Specify: W.	hite
2	72 h "natu dical	Completed	15. Decedent' (Specify only highes	s Education t grade completed)		(Give	dent's Usual Occup kind of work done	during most of work	ing 16t	o. Kind of Business/Ir	ndustry
121	vithin	ם	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT use retired	<i>'</i>		h	
d 9	Hygie ther int, th	ပ္	17. Father's Name (First, Middle, L	ast)			homemake:		e (First, Middle, Mai	own home	
Maryland	d be ental ked o	To Be	William B.	Sartai	n			Gertrud	le	Tracy	
<u>F</u>	shoul nd Ma marl marl	Ĕ	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street			ity or Town, State, Zi,	ip Code)
Š	nd 2 alth a 27 is ir trau		Philip Robert V	ernier.s	spouse	4555	Willows 1	Road. Che	sapeake B	each, MD	20732
re,	s 1 a		20a. Method of Disposition	•	20b. I	Place of Dispo	osition (Name of matory or other place	i		c. Location - City or T	
E	Page nent c nt: If		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other ( <i>S</i>		State	-		i	9-2007 S	ilver Spri	na. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee		2	2. Name and Addres	ss of Facility Ra	usch Fune	ral Home,	P.A.
<u> </u>	<b>8 3 E 8</b>	0 8	William +	500-			3325 Mt. 1	Harmony I	ane, Owin	gs, MD 20	736
ť.			23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on e	each line.						Approximate Interval Between
	Physician		immediate Cause (Final disease or condition	35	VERE	CHI	20 n.c	OBSTR	UCTIVE		Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):	7 DI	0 - 4 6 6	_		
	Examiner	_	Se wentially list conditions.	b	(or as a consec	10 PFR	7 01	20112			
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duc to	(or as a consec	quence or).					
<u>,</u>	ificate be executed g physician and is the burial-transit	Exar	that initiated events resulting in death) Last	c	(or as a consec	quence of):					
8760,	re be /sicial e buri	dical		d						ĺ	
Ф	tifical ig phy as th	edi									
ŏ	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregn		⊒Ectopic pregnancy	,		23d. Date of deliv	
<u>е</u>	ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No		nant at time of o		Other (specify)	·		Month	Day Year
<u>т</u> О	at the	Phy	9 Unknown			. 11: :- 11			OO. Didde		
Š,	The law requires that the death certific ale has been signed by the attending page 2 should be detached for use as		Part II. Other significant condition  MULTIPLE	ns contributing to d	eath but not res	sulting in the U	nderlying cause give	en in Paπ I.	23e. Did tobac	co use contribute to t	the cause of death?
20	requi	sted	co- The		11 - 1	1 .	Fracli IMBAR			2 JA0 3 F10	
Records, P.O. Box	e law has b e 2 s	Completed by			ana	- 20	IM BAK	-	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
a	rsician: The law s certificate has t lirector, page 2 s		VERTEB.	K H					performed Yes 2	death? No 1 ☐ Yes	2 □ No
₹	hysician: nis certifica I director, p	Be	25. Was case referred to medical examiner?	Hospital:		1 ED /0	- all Double	er:	h (Check only one)		
Division or Vital	Physical di	5	1 ☐ Yes ZNNo 27. Manual of Death	28a. Date	Inpatient 2  of Injury	28b. Time c	IL 3 LI DUA	4 Liprursing He	ome 5 Residence 28d. Describe how i	e 6 Other (Speci	ify)
o	nding Ph th. ; After th funeral	tion	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investig	(Mor	th, Day Year)	Injury	if 28c. Injur Worl M 1 □	k? Yes 2 □ No		.,,.,,	
/ISI	Attencr death	ifica	3 Suicide 6 Could n 4 Homicide determin	ZOU. Flaut	of injury - At h	ome, farm, st	reet, factory, office			t and Number or Rur	ral Route Number,
	s afte	Certification:	4   Hornigide	build	ing, etc. (Speci	19)			City or Town, S	tate)	
	To the Hospital or Attending Physician: within 42 hours after cleath.  To the Funeral Director; After this certifica completely filled in by the funeral director, i									e(s) and manner as	
	the H in 24 the F nplete	ledical	one)	and man	ner stated.						
	To COU	Σ	29b. Signature and title of certifier	ind. !	endy	00	29c. Licens	e number	29d.	Date signed (Month)	o 7
•			7 11 1100					1170	,	1/5/	
	15		30. Name and address of person was Anwar T. Muns					13 Drina	e Frederi	√k MD 204	578
	Sta	te	31. Date filed (Month, Day, Year)	32 F	Registra Sign	ature		O, FITIC	C LIEUELI	UN, I'III ZU(	,,,
	Registr		JUL	9 2007	Bloton	es &	Sparle				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year Physician Patricia Bradbury Watson July 2007 /Medical 8:26 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Aug. 25, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours 1 ☐ M 2 ☐ F Oklahoma 467-20-9231 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. It filem 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2√2 No Director Maryland | Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle 21710 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Hanes Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Ray Bradbury Marie Moss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 Ann W. DeArmon / Daughter 108 West College Terrace, Frederick, MD 21701 Injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Smithsburg Crematory 7/10/07 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fluneral Service Licens ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. any 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) PNO Certification: To Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Ceath Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number Date signed (Month, Day, Year) 30. Name and address 31. Date filed (Month, Day, Year) State 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2007 **Physician** 5:20 P. M June 30, Bruce Tabor Wilkins, Sr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert 515 Wesley Court, #569 Solomons 5 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) **Funeral** 06-21-1931 New York 1**X** M 2□ F 76 056-28-9870 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r 28a-f show notified at 1 □Yes 2X No MD Solomons Calvert **Funeral Director** 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number ns 23a or 2 must be n 20688 United States 515 Wesley Court, #569 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1**X** Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: Korea White Completed by 3 Widowed 4 Divorced th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cornell University Professor Emeritus 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othur any linjury or other traumatic event once. Be Alma Gladys Tabor James Rudyard Wilkins, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 515 Wesley Court, #569, Solomons, Maryland 20688 Sandra Wilkins (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 7/02/07 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Physician /Medical Due to (or as a consequence of): **Examiner** CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2▼No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

that the death certificate be executed Division or Vital Records, P.O. Box 68760, the as attending p for use as the signed by to be a detach has page certificate Physician: funeral director, After this

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

burialphysician Hospital or Attending Pl 4 hours after death. Funeral Director; After the within 24 hours at To the Funeral D

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Hospital

the

State Registrar

Medical

30. Name and address of person who completed cause of wath (Item 23a) (Type, Print) Jonathan Lowenthal, 31. Date filed (Month, Day, Year)

5 2007

29b. Signature and title of certifier

3 ☐ Suicide

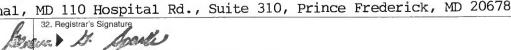
29a. Certifier

4 Homicide

(Check only

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6 Could not be determined



and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D33123

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

July 2, 2007

29d. Date signed (Month, Day, Year)

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		_	State of Maryland / State Registrar	•	rtment of He tificate of D			ene g. No.? [] [] 7	23582
	-5-		Decedent's Name (First, Middle, Last)				2. Date of Death Month	1 1/1/1/1/	3. Time of Death
П	Physicia /Medic		Blanche Estelle Wimmer	1			June 29	<b>3,</b> 2007	12:05 P <sup>M</sup>
,	Examin	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or l	Location of Death Frederic	olz.	4c. County of Dea	
			Calvert County Nursing Center  5. Social Security Number 6. Sex 7. Age (In yrs. last to	oirthday)_	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9 Bir	thplace (State or Foreign
b	Funeral Director		226-01-4619 1□ M 2\$0 F 87	Yrs.	Months Days	Hours Min.	Jan. 1	7,1920 Vi	rginia
	pu »	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, To	wn or Loc	ation				10d. Inside City Limits
	Maryla f shor	ō		nkirl	Κ.				1 □Yes 2XNo
	ith the l or 28a- oe notif	Director	10e. Street and Number 12195 Cavalier Drive		10f. Zip Code <b>207</b>	54	10	g. Citizen of What Co	ountry?
	eath w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. W	/as Decedent of His Yes, specify Cubar		ecify Yes or No-	14. Race - Ame	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Forces?  1 □ Never Married 2 ★ Married If Yes, Give Year or Dates:		Yes, specify Cubar  ☐ Yes 2 X No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	hite
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Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Juneral Service Licensee  Cary J. Coff		Name and Address	. 17		al Home Ca d. Owings	
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			(ric) tora, MD		DOO'	77153	MD	July 5,	2007
	1		30. Name and address of person who completed cause of death (Item 23	pila	Print)	hee Fren	Cruk,	MD 206	73
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrary Signature 6 2007	K	Boule	9			-
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Registrar DHMH 17 Rev 1/2001

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Funeral Director		5. Social Security N 215-56	-4703	6. Sex 1 ☐ M 2		e (In yrs. las 80	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi Jan 2	rth ay, Year	927	9. Birth Cou De	place <i>(State</i> ntry) Iawa1	or Foreign
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	2 months? ☑No	1	es, outcome ]Live birth ]Pregnant at ]Unknown	2 Fetal d	eath 3 🗆	Ectopic pre Other <i>(sp</i> e						23d. Date Mor		ery Day	Year
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Althea A. Artson 16,2007 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b\_City, Town, or Location of Death n/a yand breneral Daltimare If Under 1 Year If Under 24 Hrs. 58 Yrs. 5. Social Security Number 216 – 54 – 4484 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

W • VA Months 1□M X□F Days Hours -1949 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1X Yes 2 □ No ∟n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 3600 W. FRanklin Street, Apt, 11J 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. African-1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Healthcare Provider State of Maryland 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Leila Brown Ivory H. Hancher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 W. Franklin St., Balto, MD 21229 Eric W. Artson/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 7/25/07 Owings Mills, MD 22. Name and Address of Facility Wylie F/ H P.A. of Falto. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not after the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a co Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

/Medical Examiner Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed this After this s after dea. al Director: After

Physician/Medical

Completed by

2

Certification:

Medical

29a. Certifier

(Check only one)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Items 23a

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if teem 27 is marked oth eny linury or other traumatic event spice.

Physician

Director

Funeral

Completed by

other traumatic event, the Medical Examiner must be notified at

within 24 hours after decreased to the Funeral Directo completely filled in by the To the

> State Registrar

Waresh 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

10 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 2007 **Physician** 5:52 P <sup>M</sup> Jasvir Singh\_Athwal \*/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 □ XM 2 □ F **Funeral** Months Days Hours Min. 1956 50 8, Dec India Director 556-6**7-**8522 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No ral", or Items 23a or 28a-f sh Examiner must be notified Manchester Director Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21102 USA 2996 Manchester Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② No
If Yes, Give
Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: Asian Indian Saltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than Self Employed Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Karnail Singh Karam Kaur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mit. Pages 1 and 2 sh partment of Health an cortant: If item 27 Is r Injury or other trau Jagir Kaur, Wife 2996 Manchester Road Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If i
any Injury or 07/21/07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 22. Name and Address of Facility
MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Ligensee
Thomas Gregor 301 Fred<u>erick Road Cátonsville, MD</u> 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sa mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 1 TYes 2∏No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 N Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner Death 5 Pending investigation 1 Natural s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu

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State Registrar Malain dute, wastnumm my

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Kanene

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Theresa Μ. Aquino /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner N/A Date of Birth (Month, Day, Year)
28, 1925 If Under 24 Hrs Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2 K F 220-12-8288 82 Yrs. June Director Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show notified at Md. Harford Bel Air 1 ☐ Yes 2 X No Director r than "natural", or items 23a or 28a-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Portsmouth Ct. 21014 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White þ Specify 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 8 yrs. Housewife Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Raymon ပ Theresa Lazzaro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any Injury or other trau son-in-law Robert Castagnera 600 Portsmouth Ct. Bel Air Md. 21014 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 July 23 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 5 Other (Specify) 4 ☐ Donation Baltimore 2007 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk
7110 Sollers Point Rd. 21222 21 Stanature of F neral Service Licens 23a. Part) Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snort, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): scular Coaquilation Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): ig physician a as the burial-P.O. Box 68760. Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performe certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient P 1 ☐ Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ss of person, who completed cause of death (Item-23a) (Type, Print) M. U.40 Tabatabaeian, 32 Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician 4:00 AM 200-3 /Medical 4b. City, Town, or Location of Death Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Genes: 1 Telt, mer 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 2/5-86-/507 Usuel Residence of Decedent 1□M 2KF MANURY 10, 1968 Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health end Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notitled as Director 1 Nos 2 No ARUIANA SALTIMORE 10e. Street end Number 10f Zin Code 10g. Citizen of What Country? 451 21205 daath v Funeral akewood 11. Maritel Status . Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours efter of the of Health end Mental Hygiene. Int: If item 27 is marked other than "naturel", or ite Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. SpeCity: ð 3 Widowed 4 Divorced TrICAN AMERICAN Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WORKER Dietary 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Midgle, Maiden Sumeme) Be Alston ဂ STECENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Depertment of Health mportant: If item 27 i MARYLAND 21213 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 0 12 Burial 2 Cremetion 3 Removal from State Cemeters 4 ☐ Donation 5 ☐ Other (Specify) Dundelk, MARGIAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funera NANCY M. WALLACE MAND DIAST 3405 W. Franklin Stret-23a. Pant-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) METASTATIC CALSGA Examiner Due to (or as a consequence of) Examiner sician end buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Records, P.O. Box 68760 attending physician for use es the burie Physician/Medical Due to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 2No 3 Probably 4 Unknown þ 8 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificata has 1 Tyes 24 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: B 25. Was case referred to-medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2₽No ۵ 1 Yes 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation aftar death. 2 Accident Director: within 24 hours after dec To the Funeral Director completaly fitted in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) D0062239 MHY SICOM 161 DING son who completed cause of deeth (Item 23e) (Type, Print) 30. Name end eddress of I amelton 31. Date filed (Month, Dey, Year) 32. Register's Signeture

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4:55AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore MD Jarden If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Min 1₽M 2□ F 212-34-3523 mary lano Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Show 10b. County r 28a-f show notified at 1 √es 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 90 Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12+h 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALON ZE nari ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) owing mills TZ - aguetter 20a. Method of Disposition Burial 2 Deremation 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 3 Removal from State 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Bacto, md. 2,229 reneral Home man Approximate Interval Between Onset and Death for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immedia ause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 No 3 Probably Unknown Completed peen Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an After this certificate has funeral director, page 2 s 1 ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) No No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Iniury 5 Pending within 24 hours after deau...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 3 . Date filed (Month, Day, Year)

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N. EU

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of M	aryland			ite of L		a ivie		giene Reg. No		07	25	590
3	Q.		1. Decedent's Name		,						2	. Date of De Month	ath Da	W.	Year	3. Time o	
	Physici /Medic		Rita A	t. Bah	~						j	uly	19	· .	2007	0754	/ AM
	Examir		4a. Facility Name (If n	_						Location of D	eath	1	4c	. County	of Death		
<u> </u>			Johns Hopt	1					action							_	
Ŀ	Funeral Director		5. Social Security Nur  218-22-61  Usual Residence of D	43	ex 7. Ag □M 2√7 F	e (In yrs. la	ast birthday) Yrs.	Months	er 1 Year s Days	If Under 24 Hours	Min. N	Date of Birt (Month, Da IOV 7,	th y, Year) 192	6	9. Birthp Coun Mary	lace (State of try) Land	or Foreign
	land			10b. County		10c. City	, Town or Lo	cation							1	0d. Inside C	ity Limits
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	r 28a	Funeral Director	10e. Street and Numb	per		1		10f. Z	ip Code				10g. Ci	tizen of V	Vhat Coun	itry?	
	h wit	a D	155 S. Gr	undy Str	eet				2122	2.4				USA			
	ems ser mu	ner	11. Marital Status	unk	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Dec		spanic Origin n, Mexican, F	? (Specif	fy Yes or No	-	14. Race	e - Americ k, White,		
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	l by Fu	1 □ Never Married 3 □ Widowed 4		1 ☐ Yes 2 X If Yes, Give Year or Dates:				2 <b>∏</b> No		ucito i iii	ouri, e.c.,		Specify		ite	
5-0	72 hc 'natu dical	etec	(Specify	5. Decedent's Ed	ucation de completed)		16a. Dece	dent's Us kind of w	ual Occupa	ation luring most of }	working	un	16b. K	and of Bu	isiness/Ind	dustry	
21215-0036	ould be filed within Mental Hygiene. arked other than " atic event, the Mey	Completed by	Elementary/Second		College (1-4or	5+)	`life. I	DO NOT	use retired)	)	<b>J</b>		qu	alit	у сог	ntrol	
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/lar	uld by Menta rrked	To	Charles H	ranklin	Mitzel					Rita	Ann	ett Gi	ross				
Maryland	12 should be and Meni		19a. Informant's Nam				1	_		and Number o					State, Zip	Code)	
	1 and 2 Health em 27 i		Tony D. B.		on					treet			, MI	21	1224		
Baltimore,	Pages nent of ant: If It ary or c		4⊠Donation 5	Cremation 3	Removal from State	20b. PI ce	ace of Dispo emetery, crei	sition (N matory o	ame of r other place	9)	Dat	e	20c. L	ocation -	City or To	wn, State	
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Euro	eral Service Licen	Walde, Det	ector	St	tate	And Addres Anato	s of Facility Omy Boa MD 21	ard 1201	655 W.	Ва	1timo	ore S	treet	
T.	*		2 a. Part Enter the	disease or comp	olications that cause one cause on each li	the death						respiratory a	rrest,			Approxima Interval Be Onset and	te tween
	Physician /Medical	8 0	Immediate Cause (Fi disease or condition resulting in death)	-	a. Sep5is	5	ence of/:	***			-				- 1	Onset and	
k N	Examiner		Conventiolly that conv	diai a ma	h Examet			ver i	extre	nity							
	be sit	iner	Sequentially list conditions if any, leading to immicause. Enter Underly Cause (Disease or in	nediate ving	Due to (or as		ence of):										
•	xecut and	xar	that initiated events resulting in death) La	_	c Due to (or as	a consequ	ence of):						<del>-</del>				
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner			d												
_	rtifica ng ph as th		IE EENALE.	1000													
O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE; 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	onths?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[	⊒Ectopic ⊒ Other (	pregnancy specify)					23d. Dat Mo	e of delive	,	Year
ls, P.O.	res that tigned by	by	Part II. Other signific	ant conditions of	ontributing to death b	ut not resu	Iting in the u	nderlying	cause give	en in Part I.						ne cause of	death?
Records,	w requin been si should I	eted									_				3 ☐ Prob		
al Re		Completed									_	24a. Was autor perfo 1 Yes		- 0	orior to con death?	psy findings npletion of c 2□ No	available ause of
Vital	ician sertific ector,	Be	25. Was case referre examiner?	d to medical	Hoonital:				045-		Death (	Check only o	one)				
or	Physician: this certific	ရ	1 Yes 2 N	0	Hospital: 1 Inpatie		ER/Outpatier			4 LI Nursi		5 Resid				y)	
OU	ding I h. After funer	tion:	27. Manner of Death	5 ☐ Pending investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M	28c. Injury Work 1 □ \	rat :? /es 2∐No		d. Describe I	how inju	iry occurr	ed		
Division or	Attending or death. ector: After by the funer	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inj	ury - At hoi c. (Specify			L			f. Location (S City or Tow	Street a	nd Numb	er or Rura	l Route Nun	nber,
	ital or rs afte ral Dir led in	Cert															
	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	29a. Certifier 1 (Check only 2 one)	☐ Certifying Ph	ysician: To the best niner: On the basis o and manner st	f examinat	vledge, deat ion and/or in	h occurre vestigation	ed at the tim on, in my op	ne, date and poinion, death	olace, an occurred	d due to the at the time,	date an	s) and ma id place, a	inner as s and due to	tated. the cause(	s)
	To th withii To th comp	ž	29b. Signature and til	tle of certifier				2	9c. License					_		Day, Year)	
				72	)				RES -	000			7/1	9/07	7		
			30. Name and address	<u></u>	completed cause of c				e B	altimor	re,	MD	212	224			
	Sta Registr		31. Date filed (Month	•	007 32. gisti	ar's Signat		make	0	. * .	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Boccio ALFONSO JUL D13007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner altimou Hospita | Months | Days | Hours | Min. | B. Date of Birth (Month Day), Year | June 18, 1942 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1200MM 2 □ F 65 110-32-9097 NY Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County la or 28a-f show t be notified at NY Kings Brooklyn 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 11234 1210 USA Bergen Avenue ms 23a must b Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 120% es 2 □ No If Yes, Give Vietnam Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Manager Supermarket / Food 7 is marked other traumatic event, to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental Hiant: If item 27 is marked oth Be Thomas Facini Boccio Mary 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mayflower Lane, East Setauket, NY 11733 Cheryl Boccio / Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or either place Calverton National Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition July 25,2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Calverton, NY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute remal dou /Medical Due to (or as a consequence of): Examiner mearanoma Metastatic Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): physician s the burial Physician/Medical as attending p IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an icate has to page 2 s autopsy performed?

1 Yes 2 No certificate Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural
2 Accident 5 Pending investigation Injury within 24 hours arter community to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

107

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division or Vital Records,

State Registrar 31. Date filed (Month,

andor ha

th, Day, Year)

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2007

uan

32. Registrar's Signature

Registrar

was so figure

600 N.U

000

Street

Baltimore, MD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of ertificate or		-	giene	20592
7		St.	1. Decedent's Name (First, Middle, La		. ` _			2. Date of De	aath	3. Time of Death
	Physici /Medi		ELIZABE,	TH, B	UIE			Month	/30ay / 0 Year	102.0AM
1	Examir		4a. Facility Name (If not institution, given the second se			4b. City, Town, Ball	or Location of Dea	ath	4c. County of De	eath
	Funeral		,	Sex 7. Ag	e (In yrs. last birthday	If Under 1 Yea Months Day:			th 9. E	Birthplace (State or Foreign Country)
	Director		225-20-2955	I W Z	89 Yrs.	,		Aug 31		rth Carolina
	land M		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary -1 eh	ठ्	MD		Baltimo	re				1 Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	h with		1222 N. Gay Stree	o.†			21213		IISA	
	dea m	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of		(Specify Yes or No		nerican Indian,
36	or It		1 Never Married 2 Married	1 ☐ Yes 2 💥 If Yes, Give		1 ☐ Yes 2X N		ono moan, oto.)		
Ö	uret',	d by	3   Widowed 4 □ Divorced	Year or Dates:					Specify: b	
21215-0036	within 72 hours after death with the Maryland ane. than "naturet", or Iteme 23a or 28a-1 ehow in Madigal Examinat must be rotified at	Completed	15. Decedent's E (Specify only highest gr		(Give	edent's Usual Occi e kind of work don DO NOT use retir	a during most of w	orking	16b. Kind of Busine	ss/Industry
212	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or	5+)	us atten	,		transpor	taton
b	il Hyg othe	BeC	17. Father's Name (First, Middle, Last	)				ame (First, Middle	, Maiden Sumame)	cacon
ılar	uld be denta rked rice	ToB	James Aron Webb				Matt	ie Marks	Webb	
Maryland	d 2 sho th and ! 7 Is ma trauma		19a. Informant's Name/Relationship (William Buie/so					Rural Route Number	er, City or Town, State	), Zip Code)
	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Disp	osition (Name of	1	Date	20c. Location - City	or Town, State
JOE.	ages ent of nt: If I		1 Burial 2 Cremation 3 4 Donation 5 Other (Special		cemetery, cre	matory`or other pl	ace)		,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or iteme 23s or 28s-f ehow any Injury or other traumatic event, I'm Medical Examinat must be notified at ance.		21. Signa ure Funeral Service Licer	· · / /	ector S	2. Name and Add Eate Anai	ess of Facility Comy Boar	d 655 W.	Baltimore	Street
570	A 14		23a. Part1. Enter the disease, or com	Luce-	B.	altimore,	MD 212	201		A
3	Physician		Immediate Cause (Final	one cause on each li	110.	n Crea	4 2	ac or respiratory a	irest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Augusto (or as	a consequence of):	N Oliva	1400			
	Examiner			. Plan	nal E.	flusa	M			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):	7				
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events	a Hy	holon-	Jun				
90,	cate be executed physicien and the burial-transit	Ě	resulting in death) Last	Due to for as	a consequence of):					
8760,		dical	•	d						
× 6	500	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy			·- <u> </u>	004 044 (	I-P
Вох	eath atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify)	су		23d. Date of o	Day Year
o.	the cy the achec	nysi	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknown						
S, D	res that the death cer igned by the attendir be detached for use	by P	Part II. Other significant conditions of	contributing to death b	out not resulting in the u	anderlying cause g	iven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ğ	w require been sig should b	ed						101	Yes 2□No 3□	Probably 4 Unknown
Vital Record	law ras be	Completed						24a. Was		autopsy findings available
<u>~</u>	The ete h page	E O						autop perfo	rmed? death	o completion of cause of
/ita	cian: ertific ictor,	Be (	25. Was case referred to medical examiner?				26. Place of De	eath (Check only o		
	hysi his c	ဥ	1 ☐ Yes 2 No	Hospital: 1   Inpatie		nt 3 LI DOA		Home 5 Resid	dence 6 Other (S)	pecify)
Ĕ	ing P	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	W		28d. Describe h	how injury occurred	
Sic	Attending Physician: r death. sector: After this certific by the funeral director.	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	Α			]Yes 2 □No			
Division of	al or A	Certification;	4 Homicide determined	28e. Place of Inj	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tov	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai (	Check only 2 Medical Exar	niner: On the basis o	of my knowledge, dear f examination and/or in	h occurred at the livestigation, in my	ime, date and place	ce, and due to the	cause(s) and manner	as stated.
	To the within 2 To the Complete	Med	one) 29b. Signature and title of certifier	and manner st	ated.		se number			
	F 3 F 8		100 Miles	12	n <sub>1</sub> N	D/	17CLA		29d. Date signed (Mo	T ( Cay, Year)
		- 3	20 110	T ,	IN D.	リリー	170	7	1/1/	/
			30. Name and address of person who	ALI S	leath (Item 23a) (Type,	Site	JSt	Ballin	ma MI	1201
75	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1	- 1 %			, - /
. 53	Registr	_	JUL 2 4	LUU1	uses the	Incate 1				

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			For State Registrar	State of Maryla		artment of H rtificate of L			giene Reg. No.	3.7	23593
7	Dhyalair		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
*	Physicia /Medic		Earl A. Belt, Sr.					July	21 2	2007	1:15 a M
	Examin	er	<ol> <li>Facility Name (If not institution, give si</li> <li>Seward Avenue</li> </ol>	reet and number)		4b. City, Town, or		th	4c. County	of Death <b>Aru</b>	nđo]
17.81	Funoval		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday,	Brooklyn	If Under 24 Hrs	8. Date of Bir	th	9 Birthr	lace (State or Foreign
ь	Funeral Director			M 2□F 81	Yrs.	Months Days	Hours Min	Jan 27	, <sup>Year)</sup> 1926	Mary	Tand
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside City Limits
	Maryl. -f sho ied al	tor	Maryland Anne Aru	ndel 1	Brookly	n Park					1 ☐ Yes 2 No
	th the or 28a e notifi	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V		
	ath wil	ral	311 Seward Avenue			21225					tates
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever in Armed Forces?</li> <li>1 ▼Yes 2 No If Yes, Give Year or Dates;</li> </ol>	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 XNo	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify	e - Americ k, White, : V	
5-0	72 ho 'natur dical	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	edent's Usual Occupa e kind of work done of DO NOT use retired	ation Juring most of we	orking	16b. Kind of Bu	isiness/Ind	dustry
21215-0036	within ene. <b>than</b> "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retired, er Special			Shipbui	ldin	g/Repair
d 2	il Hygi other rent, tl	e C	17. Father's Name (First, Middle, Last)					ame (First, Middle			5, 110[10121
/lan	Menta Menta arked artic ev	To Be	Charles Belt, Sr.				Jessi	e Schrie	ber		
, Maryland	and 2 sho ealth and 27 is ma er trauma		19a. Informant's Name/Relationship (Type Frances L. Lam / Da	,	1	ing Address <i>(Street a</i> <b>/Iaryland</b> A					
altimore,	Jes 1 a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		<ul> <li>Place of Disp cemetery, cre</li> </ul>	osition (Name of ematory or other place	e)	Date	20c. Location -	City or To	wn, State
Ħ	t. Pag rtment rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)	L		ark Cemete			Baltimo		
Ba	permi Depar Impor any ir		21. Signature of Funeral Service License	mil	4	2. Name and Addres	ns Aven		imore, M		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the decause on each line.	eath. Do not en	iter the mode of dying	g, such as cardia	ac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
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V	ecuted and -transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con:	and and of						
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687	ficate physis the	edical	d.								
Box	h cert	III/III	23b. Was decedent pregnant	c. If yes, outcome pf pre		□Ectopic pregnancy				te of delive	
О. В	law requires that the death certil as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time		Other (specify)			Mo	nth	Day Year
P.0.	that the		Part II. Other significant conditions conf	ributing to death but not	resulting in the I	underlying cause give	en in Part I.	23e. Did	tobacco use cont	ribute to t	ne cause of death?
or Vital Records,	quires n sign	d by						1 🗆	Yes 2 No	3 ☐ Prob	oably 4 Unknown
000	aw require is been siç 2 should b	Completed						24a. Was	an 24b.	Were auto	psy findings available
Ä	The lav ate has page 2 t	mo						euto perfe 1 Yes	ormed?	pnor to co death? 1 □ Yes	mpletion of cause of 22 No
Vita	Physician: this certificatal director,	Be	25. Was case referred to medical examiner?	acnital:		Othe		eath (Check only	one)		
or	Physician: The la r this certificate has ral director, page 2	٦.	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ospital: 1 ☐ Inpatient 2 28a. Date of Injury	2 ER/Outpatie		4 ☐ Nursing	Home 5 Res	idence 6 Oth		y)
OU	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea		Work	(? Yes 2 □ No	200. 20001100	now injury coour		
Division	r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp.		treet, factory, office		28f. Location (	Street and Numb wn, State)	er or Rura	al Route Number,
۵	ital or ral Di lled in										
	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical		cian: To the best of my er: On the basis of exan and manner stated.							
	ro the vithin of the complex	Mec	29b. Signature and title of certifier	and marrier stated.	_	29c. License	e number		29d. Date signe	d (Month,	Day, Year)
			Je Wood &	ann		2006	53337		7-23	-20	60
•	411		30. Name and address of person who cor	npleted sause of death (		. Pa	R 11		\n \		
	1		Dorothy Seay, mi) 31. Date filed (Month, Day, Year)	32. <b>M</b> gistrar's Si	ignature	Avenue	Dall	rinove, p	AIG SIS	-09	
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DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year George H. Busick Sr. 20, July 2007 5:25p 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Middle River 815 Seneca Park Road Baltimore 8. Date of Birth (Month, Day, Year) Dec. 24, 1931 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ MM 2 □ F Days Hours Maryland 219-28-3344 75 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Seneca Park Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer BGE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Busick Marie Sauders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Busick /son Seneca Park Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Natural 2 □Cremation 3 □Removal from State Holly Hill Cemetery 7/24/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DISEASE Artoniosclero Cardiovascular Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No

**Examiner** law requires that the death certificate be executed Box 68760, P.O. Division or Vital Records, Hospital or

the burial-tra attending physician for use as the buria within 24 hours after death.

To the Funeral Director, After this

	Physician	
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	ication:	

Medical

Examiner Medical Certif

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified

and Mental Hygiene.

Department of Health ar Important: If item 27 is any Injury or other trauonce.

**Physician** 

/Medical

Pages 1

and 2 should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

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State Registrar

30. Name and address of person who completed cause

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

6 Registrar's Signature 32

29c. License number

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of death (Item 23a) (Type, Print) Hill Ctilutheroilla, MD Trim 31. Date filed (Month, Day, Year)

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Victor Bart		1-For State Control of Pleath and Wenta Certificate of Death	Reg.	No. 201	7 2650
Med	Physici ical Exam	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Duly 16, 200	Day Year	3. Time of Death 1800 hrs
			4a. Facility Name (if not institution, give street and number)  11 Severn Avenue  4b. City, Town, or Location of E Annapolis		4c. County of Deat Anne Arunde	i i
	Funeral Director		5. Social Security Number 285–78–5734 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth Min. 02/24/	MM/DD/YYYY) 9. Bi Forei	
	nd show any ice.		Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 X Yes 2 No
	th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 1009 Bayridge Avenue, #173  10f. Zip Code 21403	10g	Citizen of What Cou USA	intry?
9	21215-0036  uld he filed within 72 hours after death with the Maryland Mantel Hygiene Mantel Hygiene market other than "natural", or items 23a or 28a-f sho re event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1	uerto Rican, etc.)	White, etc.	nite
	)36 thin 72 hourse refrant "nate	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Rigger		Sail Bo	
	21215-0036 Jid he filed within 7 Mental Hygiene marked other than event, the Media	Be	Robert Bartok Hel	Name (First, Middle, Ma en Sz <del>edels)</del>	<del>ci</del> Szededski	
	MD d 2 sho lith and m 27 is aumati	To	19a. Informant's Name/Relationship (Type, Print )  Robert Bartok / Father  19b. Mailing Address (Street and Number 19b)  Northshore 20a. Method of Disposition (Name of cemetery, 19b)	B1vd. #9 La		xH 43440
<	MOF Pages nent of ant: If		1 Burial 2 Cremation 3 X Removal from State Cremation Services Inc.	7/23/2007	-	and, OH
			21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Charles L. Stevy  1501 Fast Fort  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	Avenue Bai	ltimore N	D 21230 Approximate Interval
	Physician /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		.,	Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
	ecuted and transit		events resulting in death) Last Due to (or as a consequence of):  d.			
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medical	X UNPENDED   X AMFSDED, 20b, perFH, C869, 7/24/07 TT// 23a, IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ME.g869, 7/2 23d. Date of delive Month	6V07 TT ry Day Year
1	, P.O. Erres that the designed by the	[출	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part			the cause of death?
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the star death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed		24a. Was ar autopsy perform 1 Yes 2	prior to death?	
	Vital Rec ysician: The his certificate director, page	Be (	25. Was case referred to medical examiner? Hospital: Inputient 2 FR/Outputient 3 DOA Other4			
į	n of Vit ing Physic After this funeral dire	ပ္	1 Ves 2 No Impation 2 2 2 Section 5		esidence 6 🗸 Otho	er: Scene
	on of nding Ph. th. r: After to the funeral	ion:	1 Natural 5 Pending (Month, Day, Year)		,,	
;	Divisior  Sepital or Attend hours after death. meral Director;	Certification:	2 Accident Investigation 3 Suicide 6 X. Could not be determined 4 Homicide Specify found in home	28f. Location (Str	reet and Number or R te) Ave. Annapo	tural Route Number, City
	DIVI To the Hospital or within 24 hours after To the Funeral Director Completely filled in	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	e, and due to the cause	(s) and manner as sta	ited.
	- s + 5	Ĕ	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
	7		30. Name and address of person who completed cause of death (Item 23a)  To be One of the MD Assistant Medical Examinary 111 Bonn Street Boltimore	MD 24204	July 17, 2007	
U		tate	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore  31. Date filed (Month, Day, Year) 32. Registrar's Signature	e, IVID 21201		
	د Regis		1111 0 4 2007 6			

### 07-05519

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 1040	. , , ,	
Steven Elrick Brandon, Sr.	State of Maryland / Department of Health a	and Mental Hygier

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Steven  4a. Facility Name (if not institution, give street and number)  Harbor Hospital  Steven  F. Brandon Sr July 18, 2007  4b. City, Town, or Location of Death  Baltimore	3. Time of Death Year 1743 hrs
4a. Facility Name (if not institution, give street and number)  Harbor Hospital  Baltimore	
Harbor Hospital Baltimore	nty of Death
5, Social Security Number 0. Sex 77 Ago (111 ) 15. Rost Strategy	YYY) 9. Birthplace (State or Foreign
Director 218-84-5178 1X M 2 F 41 Yrs. Months Days Hours Min. 09 02 65	
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	1 X Yes 2 No
MD NA Baltimore  10g. Citizen of Street and Number.  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent Sumulation or Information or Infor	of What Country?
## ## # # # # # # # # # # # # # # # #	I.S.A.
1005 Mt Holly Street 1. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Quban, Mexican, Puerto Rican, etc.)  14. R  17. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Quban, Mexican, Puerto Rican, etc.)	Race - American Indian, Black, White, etc.
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. R  Armed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. R  Ves X No. specify:  Spec	cify: Black
3 Widowed 4 Divorced If Yes, Give Year 1 1 Yes No specify: Specify	of Business/Industry
3 Widowed 4 Divorced in res. (average)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4 or 5+)	THE RESERVE TO SERVE
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10th grade na Porter  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surn.  19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Number or Rural Route Number, City or 19. Mailing Address (Street and Numbe	Town State Zin Code)
The property of the property o	
Katie L. Brandon-Mother 1005 Mt. Holly Street, Balti	tion - City of Town, State
The state of the s	
20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other place)  1 X Burial 2 Cremation 3 Removal from State crematory or other place)  1 X Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  March F/H West	dallstown, Md
	o. Md 21215
Playsician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or	or heart Approxim e nterval  Between Onset and
Medical Librardiate Course (Final disease on each limit.	Death
xaminer r condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):	
Chisease or injury that initiated	
Due to (or as a consequence or).	
d	
Of the region of	ate of delivery
23b. Was decedent pregnant in the past 12 months?  Live birth  2 Fetal death  3 Ectopic pregnancy  Months	onth Day Year
4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown	V.
M 39 4 59 C Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use	contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Yes 2 No.	o 3 Probably 4 Unknown
24a. Was an autopsy performed?  1 ✓ Yes 2 No  26 Place of Death (Check only one)	24b. Were autopsy findings available prior to completion of cause of
performed? 1 ✓ Yes 2 No	death? 1 ✓ Yes 2 No
25. Was case referred to medical 26. Place of Death (Check only one)	
Les up 25 of the control of the cont	e 6 Other:
1 ✓ Yes 2 No 1 inpatient 2 ✓ Errotupatent 3 Don 1 victorial victo	occurred
Unity of the last	D. I.B. I. Market City
28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Solution of Surface and solution or Town, State) Solution of Surface and solution or Town, State) Solution of Surface and solution or Town, State) Solution of Surface and solution or Town, State) Solution of Surface and solution or Town, State)	Number or Rural Route Number, City
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	, and due to the cause(s)
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.  29d. Date of the control of the time, date and place, and manner stated.  29d. Date of the control of the time, date and place, and manner stated.  29d. Date of the control of the time, date and place, and manner stated.  29d. Date of the control of the time, date and place, and manner stated.	te signed (Month, Day, Year)
	9, 2007
30. Name and address of person who completed cause of death (Item 23a)	
Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Argana, Day, Year) 2007 32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ΡάΥ, Physician .TIII.Y 2007 11:30 A M LUCILLE VIOLA BUCHANAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 80 May 1927 Maryland 214-24-6731 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Directo Maryland Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1256 West Jarrettsville Road 21050 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner ane. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3₺ Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Serina Hollingsworth Howard Arthur Norton ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teri. L. Buchanan / Daughter 1256 West Jarrettsville Rd., Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7- 23-07 Bel Air Memorial Bel Air, Marvland 21. Signature Funeral Service License 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician le C disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes this certificate or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 📐 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD 21014 - BEL AIR, MD. DAVID DUNN 31. Date filed (Month, Day, Year) 32. Regiştrar's Signature

State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

90 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:10 P M Ruth Marion Boniface July 20, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 136 Priestford Road Churchville Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕇 F Yrs. Director 079-10-9063 92 1915 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow 7 is marked other then "natural", or items 23a or 28a-f shot treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2√2 No Directo Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hyglene. 136 Priestford Road Funeral 21028 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Administrator County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental H Be Lanson William Mosher Marion Ella Coon ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Item 27 136 Priestford Road, Churchville, Maryland 21028 be of Disposition (Name of Date 20c. Location - City or Town, State Carol L. Boniface / Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Little Falls Friends 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department o Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Meeting Cemetery 7-24-07 Fallston, Maryland 21. Signature of Juneral Service Licens McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LOUDING mont disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the deeth certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 2 NO 1 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed certificate has b 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2NNo 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient examiner' Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 22 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending i after death.

i Director: After d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funerail 29a. Certifier Exitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of who completed cause of death (Item 23a) (Type, Print) 303 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

#### Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Ronnie Charles Cheek 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORECITY GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours **№**M 2□ F 219-54-3920 56 Director Aug. 19, 1950 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at onee. Directo MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5622 Woodmont Avenue Apt. D 21239 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married Married Specify: African 1 ☐ Yes 2**K** No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) fire fighter Baltimore City Fire Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Cheek Maggie Dockery ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecilia P. Cheek / Wife 5622 Woodmont Avenue Apt. D; Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Removal from State Garrison Forest Vet. Cem. 07/30/2007 Owings Mills, Maryland 4 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home of Baltimore Co. ature of Funeral Service Licenses 1 CMOCM 9200 Liberty Road; Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician INTRA CRANIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** YPERTENSION Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence off Examiner law requires that the death certificate be executed Renal Stage and burial-trar Due to (or as a consequence of): attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24a. Was an autopsy has perform certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this ٩ Division or funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation Natural Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

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3. Time of Death

11:54 1.M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 X Yes 2 □ No

Year

07

USA

Black, White, etc.

Month

29d. Date signed (Month, Day, Year)

MP

American

DHMH 17 Rev 1/2001

State Registrar

one)

29b. Signature and title of certifier

Deep Sharma

31. Date filed (Month, Day, Year)

**ORIGINAL** 

Sharma, MD

32. Reniştrar's Signature

Samaritan

Good

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES 000

Bellinore

State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #5, perFH,0870, 8/1/2007 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mildred C. Calvert 2007 /Medical Town, or Location of Death 4c County of Death 4a. Facility Name (If not institution, give street and number, Examiner Franklin Square Baltimore ital eda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6396<sup>6</sup>. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Min. Months Days Hours 1□M 2□xF 218-22-<del>6346</del> Director 81 March22,1926 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show at a or 28a-f sh 1 ☐ Yes 2X No MD Baltimore Director Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19 Tamarac Trail 21220 USA items 23a **Examiner must** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: White Specify. þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 11+h Is marked other Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I and 2 should be fi lealth and Mental H Harry Brown Margaret Musgrove ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau Barbara Maddox /daughter 13019 Eastern Ave. Baltimroe MD 21220 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Holly Hill Cemetery 7/24/07 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Fundral Service License 300 Mace Ave. Balto. MD 23a. Part1 Enter the disease shook, or heart failure. Connelly Funeral Home of Essex 21221 ications that cause in each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons duence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE use lf yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Por Month 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9∏Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No Inpatient 1 🔲 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 2 this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Y I 6 Ž867 **Physician** 10:10 AM delaide /Medical 4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER 4b. City, Town, or Location of Death TOWSON BALTIMORE Examiner 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 207-22-2037 04.04.1924 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 No Bastimore Director Towson the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA Acorn Apt 101 2860 Circle Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 14 OUnstor Mt. Wilson Itospitas 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) harles G. Minnie Stevens Mamas Baltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is any injury or other trau once. Patricia G Acorn Circle Daughter lauson MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Ma Buria! 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Allress of Facility Vougha C. Green united Service Arlington Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ind Mandalistan MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final Physician unknown disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours a To the Funeral I

State Registrar 29b. Signature and title of certifier

Jeff- 4

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

-/icht,

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2007 DHN H . 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Taryl AND UNIVERSITY OF 5. Social Security Number MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Director Oct. 10,1919 219-12-6595 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9219 Carlisle Avenue Funeral U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 N Yes 2 No 1941− If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 M Married 1 ☐ Yes 2X No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Roofing Contracting Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John H. Cole, Sr. Mary Hartman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Cole (Wife) 9219 Carlisle Ave., Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Garrison Forest 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State **Physician** /Medical Examiner Examiner ician and burial-trans ending physician use as the buria Physician/Medical atter for u been signed by the should be detached Completed by page 2 certificate Be Certification: To After thi funeral death.

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

Medical State Registrar DHMH 17 Rev 1/2001

4 Donation 5 Dottler (Specia	vecerans demetery 0//2//	2007 Owings Mills, Maryland
21. Signature of Funeral Service Lice	1see 22. Name and Address of Facility Sch	imunek Funeral Home Inc.
Difame	Rweles 9705 Belair Rd., Bal	ltimore, Maryland 21236
23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the mode of dying, such as cardiac or one cause on each line.	respiratory arrest, Approximate Interval Between
Immediate Cause (Final disease or condition	a CLOSED HEAD INJURY	Onset and Death
resulting in death)	Due to (or as a consequence of):	N I WER
		Interval Between Onset and Death  Approved by Metacal Examiner  Approved by Metacal Examiner
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	D BY ME
cause. Enter Underlying Cause (Disease or injury that initiated events		APPROVE
resulting in death) Last	Due to (or as a consequence of):  CERTIFICATION	NPPROVED BY METICAL EXAMINER
	_d	
IF FEMALE:	23c. If yes, outcome pf pregnancy	
23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 5□ Other (specify) 9□Unknown	
	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
COROHARY	ARTERY DISEASE	1 Yes 2 No 3 Probably 4 Unknown
ABDOM, NAL	LORTIC ANEUZYSM	24a. Was an 24b. Were autopsy findings available
		autopsy prior to completion of cause of death?
25. Was case referred to medical	OC Please ( Park)	1 Yes 2 No 1 Yes 2 No
examiner?	26. Place of Death ( Hospital: 1 Tipostient 2 DEB/Outpatient 3 DOA Other:	
27. Manner of Death	12 inpatient 2 11 routpatient 3 1 SOA 1 4 Industring Home	e 5 Residence 6 Other (Specify)
1 ☐ Natural 5 ☐ Pending	(Month, Day Year) Injury Work?	d. Describe how injury occurred
2 Accident investigation 3 Suicide 6 Could not be	July 20, 2007 12.30	+ALL
4 Homicide determined	28e. Face of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
	HOME 92	19 Carliste Ave. Zizste
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	sysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1 Hotel	~m P17640	JULY 22, 2007
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	· · · · · · · · · · · · · · · · · · ·
JEFF ZILBERS	STEIN, MD 22 S GREENE ST	BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

JUL 2 4

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death currence Telle **Physician** Numer 2. 10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Good Samaritan Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Yrs **Director** 232-36-6087 78 Sept. 17,1928 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f sh notified 1 X Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 4310 Stanwood Avenue 21206 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White 'natural" Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Sparrow Point Ship Elementary/Secondary (0-12) Carpenter Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Numer W. Currence ပ Ruby Dunkle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Jones (Daughter) 151 Lantern Lane, Stewartstown, Pa. 17363 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maplewood Cemetery 07/26/2007 Elkins, West Virginia 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ig physician and as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.O. I 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 No autopsy 2 No 1□ Yes Il or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 No Other: 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral dir Certification; To 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After (Month, Day Year) To the Hospital or within 24 hours after death. To the Funeral Director: After memberely filled in by the fur 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tury 23 200

Registrar DHMH 17 Rev 1/2001

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**ORIGINAL** 

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Rallen

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CONNINGHAM 6-45 AM RICHARD E 07 21 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Medical Hartord Center I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1**X** M 2□F 221-12-6248 Delaware 27-1926 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Belcamp Harford ld 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA rcle 2101 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 NYes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) stere 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **こう 不 ろ の そ う** UNKNOWN 19a. Informant's Name/Relationship (Type. Print) daugnter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Cunningham Date Delcamp Maryland 21017 20c. Location - City of Town, State 4319 Winners inlawl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-25-2007 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) orraine Park Cometry 22. Name and Address of Ficility Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville Maryland 21234 21. Sign ur of Funeral Service Lice see or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final RESPIRATORY ACUTE 3 days disease or condition resulting in death) Due to (or as a consequence of): EARS CHRONIC OBSTRUCTIVE DISEASE PULMONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month 5 Other (specify) 9 Unknown

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**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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27. Manner of Death  1	7 7
3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	
29b. Signature and title of certifier a.D. ATTENDING 29c. License	number 29d. Date signed (Month, Day, Year) 21207

VELLA-CAMILLERI FRANZ C. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHYSICIAN

5 MIDCREST CT.

BACTINDRE, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 360 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vear **Physician** Corra 1815 ella 200 a /Medical Town, or Location of Death Facility Name (If not institution, give sweet and number) 4c. County of Death Examiner lls nda I more. west Jor Hospita town, If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Director 213-32-9613 03 MD 10 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits , or items 23a or 28a-f show notified at YYes 2□No Director Baltimore MD NA 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code Medical Examiner must be 21207 U.S.A. 6108 Meadow Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "na any injury or other traumatic event at anone. Elementary/Secondary (0-12) College (1-4or 5+) Private Duty 12th grade na Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ George Hicks Hazel Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 6108 Meadow Ave, Baltimore, Melrow Corry-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 7/24/07 Arbutus, Md 21. Signature of Funeral Service March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequent of): ar /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 certificate has autopsy performe death? 1 □ Yes 2 □ No 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 No 2 ER/Outpatient P 1 🗌 Yes 1 Inpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: After Hospital or Attending 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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### 07-05501 Tavon Clark

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Hosp 24 hc Fum	_	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowle	edge, death occur	rred at the time, da tion, in my opinion	ite and place, and death occurred a	uue to the cause( t the time, date ar	nd place, and due	to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death or the this certificate has been signed by the attending physici. To necessary the finest director, page 2 should be detached for use as the burnt nearly little in whe finest director, page 2 should be detached for use as the burnt.	Medical		and mariner stated.	and/or mivestiga				29d. Date signed	(Month, Day, Year)
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5		Donna M. Vincenti, M.		aminer 11	1 Penn Street,	Baltimore, M	D 21201		
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/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County	2007 12:35 A M
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th with t 23a or 2 ust be n	<b>Funeral Director</b>	10e. Street and Number 119 North Meadow Drive		10f. Zip Code 2106	60		10g. Citizen of W	/hat Country? /SA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 1 2 Divorced  12. Was Decedent Everal Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify	e - American Indian, k, White, etc. white
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Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a condition or as a	onsequence of):	,				2 Wc
Examiner of the sansition of the sansiti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):	+TN				yeer
tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last Due to (or as a c	onsequence of):					
The law requires that the death certificate has been signed by the attending plange 2 should be detached for use as to	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12-ponths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify)	1		23d. Date Mor	e of delivery hth Day Year
es that tigned by	y Ph	Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
w require						1 □ Y	es 2 No	3 ☐ Probably 4 ☐ Unknown
	Completed			·		24a. Was a autops perfori 1□ Yes	med? d	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 ☐ No
stcian: The certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:		ot 3 DOA Othe	26. Place of Death	(Check only on	ne)	MANORIA
ding Phys	ion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Y	2 ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	4 LI Nursing Ho		ence 6 Othe ow injury occurre	ed HOUSE
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (	- At home, farm, str Specify)			28f. Location (Si City or Town		er or Rural Route Number,
he Hospit in 24 hours he Funers pletely fille	Medical (	29a. Certifier (Check only one) Certifying Physician: To the best of results of examiner: On the basis of examiner and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the c ed at the time, d	ause(s) and mar late and place, a	nner as stated. and due to the cause(s)
To t With Com	Σ (	29b. Siggature and tifle of certifier		29c. License	) 2143	8 2	9d. Date signed	(Month, Day, Year) 4 23 2007
10		30. Name and address of person who completed cause of deat MICH AEL J. La KN TH W	4450	EFENSE	H6HWA	1 ANA	IAPOLIS	Mn 2401
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's	Signature					
IMH 17 Rev 1/20		JUL 2 4 2007 Men	15 19	ever -				
			OR	IGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

07-05594 Brian K. Cooper

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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6		J.	j		0	0	U	U

סוום	ari K. Cooper		1- For State Criticate of Death	Reg	No.	
B.O	Physicia	n/	Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death Month E July 21, 200	ay Year	3. Time of Death 0737 hrs
₩e	ਰਾਤਕl Exami		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	July 21, 200	4c. County of Dea	
			Good Samaritan Hospital Baltimore		N	1:1
1	Funeral Director	- 1	5. Social Security Number 6. Sex 1.5 - 84 - 210) 6. Sex 1.5 - 84 - 210) 6. Sex 1.5 - 84 - 210) 6. Sex 1.5 - 84 - 210) 6. Sex 1.5 - 84 - 210) 7. Age (In yrs. last birthday) 45 Yrs. Months Days Hours Min		(MM/DD/YYYY) 9. B Fore	
	e	4,0 50 .	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County           10c. City, Town or Location		<i></i>	10d. Inside City Limits
5	<b>*</b>	٦	MD N/A Baltmore	-17	•	1 LYes 2 No
1	Baltimore, MD 21215-0036 semit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Meintal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show njury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number  133 (o Silven thorn Road 21239	10g	. Citizen of What Co	
0	eath with the items 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S			rican Indian, Black,
	or death	Funeral	1 Yes 2 No	rijodni, oto.)	7	Frican
***	urs afte	<u>چ</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business	Industry
	21215-0036 hould be filed within 72 hours al of Mental Hygiene. is marked other than "natural tite event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret	ired)	(	structur
	OO3	e e	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, Ma		STOW CHUY)
	ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be C	Mack Lee Cooper A	nn R.	RUSS	
	21 hould I nd Mer is mar	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or			
	ore, MD es 1 and 2 sho of Health and If item 27 is	-	Ann R. Cooper/mother 1336 Silverthon 20a. Melhod of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
/	More Pages 1. nent of 11. ant; If it		1 Burial 2 Cremation 3 Removal from State crematory or other place)	27/02	Arhus	)s Mn
1	Baftimore, permit. Pages 1 ar Department of 11st Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State Crematory of other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5 6 5 1 2 6 Below 12	Funen	a Serv	12. P.A.
		4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Re ad a	Ball Howard	Approximate Interval
	Physician Vledical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Continues and alcoholism			Between Onset and Death
	aminer		or condition resulting in death)  Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate bulbe to (or as a consequence of):			
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    C.    Due to (or as a consequence of):			-
	executed an and al - transit		d.			
	60, ate be exe physician a	Medical	X   AMENDED   7 per fh   8869 /-24-0/ vt   #23a,27, per ME, g870, 8/22/07 TT		1	
	68760, certificate be nding physici		IF FEMALE: 23b. Was decedent pregnant in the 2ctopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delive Month	Day Year
	Box 687 e death certific the attending p ed for use as th	sician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  9 Unknown			
		Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
	F. P. (ires that signed be det	d by		1 Yes		obably 4 Unknown
	ords w requ as been	Completed		24a. Was ar	y prior t	autopsy findings available ocompletion of cause of
	Rec The la icate h	E O		perform 1 <b>Y</b> Yes 2		
	ital sician: s certif irector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nurs	,	Residence 6 Ott	ner:
	ing Physician: The law requi After this certificate has been uneral director, page 2 should	<u>۽</u>	1 ✓ Yes 2 No  27. Manner of Death  28s. Date of Injury (Month Day Year)  28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
	tendii death. tor: A	atio	1 X Natural 5 Pending 2 Accident Investigation			
	Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	3 Suicide 6 Could not be determined (Specify)	28f. Location (St or Town, Sta		Rural Route Number, City
D	Hospit: 24 hour Funera		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cause	(s) and manner as s	ated.
## ## ## ## ## ## ## ## ## ## ## ## ##						the cause(s)
1		Σ	29b. Signature and title of certifier  O.C.M.E.		29d. Date signed (# July 22, 2007	riontn, Day,Year)
1	الررا		30. Name and address of person who completed cause of death (Item 23a)			
101	P		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	St Regis	ate rar	31. Date filed (Monte)			
		_				

ORIGINAL

DONTE CAMONT CHASE

07-05557

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	1-	State of Maryland		ificate of		ind wichte	ar r rygione	Dea No		Jell
Physician/	R	egistrar . Decedent's Name (First, Middle,Last)		modite or			2. Date of D		Year	3. Time of Death
le Examine		DONTE LAMONT CHASE					Month July 19,			1556 hrs
	4	a. Facility Name (if not institution, give street and numbe 3000 block Clifton Park Terrace	-)	4	lb, City, Town, Baltimore	or Location of	Death	40	c. County of Deat N/A	
	E		ge (In yrs. las	t birthday)	If Under 1 Y		24Hrs. 8. Date of	Birth(MM	/DD/YYYY) 9. Bi	rthplace (State or
Funeral Director	١	216-94-3018 <sub>1x M 2 F</sub>	27	Yrs		ays Hours	Min.	1980	Forei Co	ountry) MARYLAND
	Ţ	Jsual Residence of Decedent			<u> </u>		1 2-9-	1 900		
v any	1	0a. State 10b. County		own or Locati						10d. Inside City Limits 1 XYes 2 No
Aaryland 28a-f show any 1 at once.	ΞL	MD. N/A	D D	ALI IMOI	10f. Zip Code	<u> </u>		10g. Cit	tizen of What Cou	-21
th the Maryland 23a or 28a-f sho notified at once	3   1	0e. Street and Number  3 SILVERTON RD. APT 3C			212				USA	
vith th		1. Marital Status 12. Was Deceder	nt Ever in U.S	. 13. Wa	s Decedent of	Hispanic Origin	n? ( Specify Yes or		14. Race - Ame	rican Indian, Black,
r death with or items 23 must be no		1 X Never Married 2 Married Armed Forces	s? 2 <b>X</b> No				Puerto Rican, etc.)	(10)	White, etc.	
	- 1	Widowed 4 Divorced If Yes, Give Year or Dates:			Yes 2 X		ind of work done	116h	Specify: BLA Kind of Business	-
hours natur Exam		15. Decedent's Education (Specify only highest grade or Elementary/Secondary (0-12) College (1-4 or	,			life, DO NOT u		/	Taria of Beeninese	
136 thin 72 than than edical	ompieted	-110-		LABO	ORER				CONSTRUC	TION
	١١	17. Father's Name (First, Middle, Last)				1	Name (First, Midd		n Surname)	
	e Pe	LEWIS E . CHASE  19a. Informant's Name/Relationship (Type, Print )		19b. Mailin	a Address (S		ENISE PEN per or Rural Route		City or Town, Star	te, Zip Code)
MD 2  Id 2 shoul  Ifth and M  m 27 is m  aumatic	<u> </u>	DENISE PENN(MOTHER)					BALTIMOR			
	Ť	20a. Method of Disposition		lace of Dispos rematory or ot	sition (Name of her place)	f cemetery,	Date	20c	. Location - City o	or Town, State
MOT Pages ent of int: 16	1	1 A Burial 2 Cromation 3 Removal from 4 Donation 5 Other Specify:	MT.	ZION (	CEMETER	Y ,	7-26-2007	BA	LTIMORE.	MARYLAND
Baltimore, permit. Pages I as permit. Pages I as Department of He Important: If ite injury or other tr	1	21. Sign. neral Service Licenses 10								
	4	23a. P /1, Enter the disease, or complications the caus	ed the death.	Do not enter	the mode of dy	N. MONE ing, such as ca	ROE ST Bardiac or respiratory	ALTTI arrest, st	MORE MA hock, or heart	RYLAND 21217 Approximate Interval
Physician ledical		foliur. List only one cause on each line.								Between Onset and Death
aminer	1	Immed are Cause (Final disease or condition resulting in death)  a. With the Guns or condition resulting in death)								
	_	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a column of the conditions)	sequence of	):				_		1
	Examiner	Clicase or injury that initiated								
r led	EX	events resulting in death) Last Due to (or as a co	nsequence of	):						
b0, te be executed ysician and burial - transit	edical	UNPENDED AMENDED								
760, cate be physici		IF FEMALE: 23c. If yes, out						2	3d. Date of deliv	
Box 6876: e death certificate the attending phy ed for use as the	Physician/N	23b. Was decedent pregnant in the past 12 months?	at time of dea		etal death other (Specify)	3 Ectopic	pregnancy	Į	Month	Day Year
Box le death the atte	)si	1 Yes 2 No 9 Unknown 9 Unknown								the same of death?
P.O.	g S	Part II. Other significant conditions contributing to de	ath but not re	esulting in the	underlying cau	use given in Pa				to the cause of death?
S, P	8 8 8						- 13	Vas an	24b. Were	autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death.  The Invertor: After this certificate has been in the fameral director, page 2 should be the funeral director, page 2 should be a should	Completed							autopsy performed	? death	
ital Recician: The scertificate rector, page		25. Was case referred to medical			26.6	Place of Death	(Check only one)	es 2	No 1 🗸	Yes 2 No
Vital ysician his cert directo	ŏ١	evaminer?	atient 2	ER/Outpatier		Other:	Nursing Home	Resi	idence 6 🗸 Ot	her: Scene
n of \ding Phy	의	27. Manner of Death 28a. Date of (Month), D.	Injury ex.Year)	28b. Time of	Injury 28c	. Injury at Work	Subject		injury occurred	
ision Attendi rector: /	읉	2 Applicant Investigation		1550 hrs	1	Yes 2 ✔	No		t and Number or	Rural Route Number, City
Divis  Divis  pital or A  ours after  filled in by	Certification:	Suicide Could not be	f Injury - At hi _ocal Stree		eet, factory, or	fice building, et	or To	um State		
hou hou		29a. Certifier 1 Certifying Physician: To the best of	f my knowled	ge, death occ	urred at the tim	ne, date and pla	ace, and due to the	cause(s)	and manner as s	tated.
To the Hos within 24 h To the Fur completely	Medical	one) Medical Examiner: On the basis of and manner state	examination a	nd/or investig	ation, in my op	oinion, death oc	ccurred at the time,	date and	place, and due to	the cause(s)
F F F S	Me	29b. Signature and title of certifler	Λ			icense number				Month, Day, Year)
7		( let obem	)			).C.M.E.		ال	uly 20, 2007	
6		30. Name and address of person who completed cause Laron Locke MD. Assistant Medical		111 Per	n Street. B	saltimore, M	1D 21201			
Sta	ato		trar's Signati		haste			_		
316	اتند	7111V / (VIIIV 75	748.1C1	A. A	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 10:13 PM Chase **Physician** Anthon 18 VLU 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) Examiner 40spital Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yes. last birthday) **Funeral** 1 M 2 □ F Days Hours Min. Months 77-539 Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County fshow Items 23a or 28a-f showner must be notified at 1 ∑Yes 2 No Director a 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 1229 Examiner must by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ② No "natural", or Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed and Mental Hygiene.
Is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 Is
any Injury or other trau 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 ⊠ Burial 2 □ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final congenital heart disease 9 months **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): tailure Examiner renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine ed by the attending physician and detached for use as the burial-transit sepsis The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be dev þ syndrome 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed prematuriti 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate 1 To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes this 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Medical Certification: within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation Year 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000

State

600 N. Wolfe Street Baltimore

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

tettes

31. Date filed (Month, Day, Year)

JUL 24

			1 - For Stata Registrar	State of N	Maryland /		nent of H cate of L		d Mental Hy	giene Rag. No		2361
	Physic	ian	Decedent's Name (First, Middle, La	st)					2. Date of De	ath 3. Time of Death		
	/Medi		Lorena G. DeCar						July 1		2007	9:35 AM M
	Exami	ner	4a. Facility Name (If not institution, given		or)	4b.	. City, Town, or	Location of De	eath	40	. County of Death	
			349 Overlook Dr				Lust				Calvert	
ı	Funeral Director		219-48-5619	Sex 7. / 1□M 2∑F	Age (In yrs. last b		Under 1 Year onths Days	If Under 24 H	Irs. 8. Date of Bir in. (Month, Da July 2	$\overset{\text{rth}}{2}$ , $\overset{\text{rear}}{1}$	9. Birthi Coul. 947 Nort	place (State or Foreign ntry) h Carolina
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	en or Locatio			·			10d Incide City Limite
	r 28a-f ehow	5										1 ☐ Yes 2 ☐ No
	28a-	Director	MD Calv	ert	Ll	ısby	of Tin Code			10- 01		
	death with the Maryland ms 23a or 28a-f ehow Linust be notified at	ā	349 Overlook Dri	WA.		1	Of, Zip Code	20657		iog. Ci	tizen of What Cour USA	ntry r
	leath	era	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13 Was			(Specify Yes or No		14. Race - Americ	can Indian
980	hours after o tural', or iter	by Funeral	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Force 1 Tes 24 If Yes, Give Year or Dates	§? ∃ No		s, specify Cubai res 2 X No	Specify:	(Specify Yes or No erto Rican, etc.)		Black, White,	etc.
9	72 ho	ted	15. Decedent's E	ducation	16a	a. Decedent's	Usual Occupa	tion	unk	16b. K	ind of Business/In	dustry unk
Maryland 21215-0036	within ene. then	Be Completed	(Specify only highest grant   Elementary/Secondary (0-12)   unk	College (1-40 unk	r 5+)	life. DO N	of work done d IOT use retired,	uring most of u	vorking			
Б	be filed tal Hygi d other	3e C	17. Father's Name (First, Middle, Last	)				18. Mother's N	lame (First, Middle	, Maider	Sumame)	
la l	Mental Mental arked c	To E	Calvin Guy Long					Margar	et Cleo N	Wins	tead	
	d 2 sho th and 7 is my traum		19a. Informant's Name/Relationship ( Donald DeCarr/spo						Rural Route Numb		or Town, State, Zip	Code)
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special			of Disposition ary, cremator	(Name of y or other place	)	Date	20c. L	ocation - City or To	own, State
Balt	permit. Departr Imports eny inj		21. Signature Funeral Service Licentification S.	Wade vi	ector	State Balt:	me and Addres e Anato imore,	my Boan MD 212	ed 655 W.	Ba1	timore S	treet
68760,	Physician be executed by Medicale Personned Bayesician and as the prival-transit	sai Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Quise (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. REN Due to (or a b. Due to (or a	_	ANCE of):				ME	7.5	Onset and Death
P.O. Box 687	The law requires that the death certificate the has been signed by the attending phypage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□ Pregnant 9□ Unknown	2 □ Fetal death at time of death	5 Othe	pic pregnancy er (specify)				23d. Date of delive Month	ory Day Year
	quires tha in signed uld be de	þ	Part II. Other significant conditions of	ontributing to death			ring cause give	n in Part I.	23e. Did t		use contribute to th	ne cause of death?
I Records,	stcian: The law requir. certificete has been si irector, page 2 should b	Completed					<del></del>				prior to cor death?	psy findings available πpletion of cause of 2 No
/ita	cian: artific ctor,	Be (	25. Was case referred to medical examiner?		-0.000.00			26. Place of D	eath Check only o		-	
<u></u>	hysic his o	2	1 Tes 2 ™o	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Ou	utpatient 3[	DOA Other	4 Nursing	Home 5 Resid	dence	6 □Other (Specif)	/)
Division of Vital	nding P eth. r: After t ie funera		27. Manner of Death  1	28a. Date of In (Month, D		Time of Injury M	28c. Injury Work 1 □ Y	at ? es 2 □ No	28d. Describe I	how injur	y occurred	
Divis	To the Hospital or Attending Physician: The I within 2 Hours after death. To the Euneral Director: After this certificete ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place of Ir	njury - At home, fa tc. (Specify)	arm, street, fa	actory, office		28f. Location (S City or Tov		d Number or Rura	l Route Number,
	the Hospi in 24 hou he Funer pletely fill	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysicien: To the bes niner: On the basis and manners	ot examination an	e, death occu nd/or investig	irred at the time ation, in my opi	e, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	2//			29c. License	number		29d. Dat	te signed (Month, i	Day, Year)
							DB	6969		71	18107	
			30. Name and address of person who SCARIA MAT	completed cause of			89 L	.USBy	MD2	065	, 7	
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature	1	9					

DEBORD, PATRICIA

	hysicia /Medic	_	Patricia Ann DeB	ord				JULY NI SOUT 9:20 PM				
4.3	xamin		4a. Facility Name (If not institution, gi			4b. City, Town, or			4c. County of De	eath		
				TOSPETAL  Sex 7. Age (In yr.	last hirth		If Under 24 Hrs	MD <sub>7</sub> 212 8. Date of Bir		Birthplace (State or Foreign		
	neral ector		217-62-6643	1□ M 2X F 56		rs. Months Days	Hours Min.		av. Year)	rth Carolina		
dand	at ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town	or Location				10d. Inside City Limits		
Mary	fled a	ţo	MD N/	A	Bal	timore				1 MgYes 2 □ No		
th the	e not	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?		
ath wi	ust b	ral	4509 Cedar Garde				1229		United States			
er de	ner m	Funeral	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 XNo	U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (S an, Mexican, Pue	14. Race - American Indian, Black, White, etc.				
1d 21215-0036  P filed within 72 hours after death with the Maryland II Hygiene.	d other than "natural"; or items 23a or 28a-1 show event, the Medical Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White		
<b>15-(</b>	natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. [	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	ation during most of wo	16b. Kind of Busine	ss/Industry			
withir	than Me	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		Administrat			State Go	vernment		
Hyg	other ent, t	Be C	17. Father's Name (First, Middle, Las	t)	1	Administrac			e, Maiden Surname)	verment		
/lan	0 0	유	William DeBord				Cathe	bury				
0 0 0	∞ ≅		19a. Informant's Name/Relationship	, , ,	1	,		er, City or Town, State, Zip Code)				
	other tr		Mr. William DeBo			27 Grinnald		Baltir	nore, Mary			
Se to	= 0		1 ☐ Burial 2 ☐ Cremation 3 [	_Hemovai from State		Disposition (Name of crematory or other place	1		,	·		
nit. P	Important: II any injury o once,		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Bayv	iew Cremato 22. Name and Addre				e, Maryland		
Balt permit. Depart	a a g		I will Us	Lin		1	•	Hubbard we. Bali	Funeral Ho	ome, Inc. ryland 21229		
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the de	ath. Do no					Approximate Interval Between		
Phys	ician		Immediate Cause (Final disease or condition	. Small CE	u l	UNG CAR	CINON	Α.		Onset and Death		
	dical niner		resulting in death)	Due to (or as a conse								
LAGII		-	Sequentially list conditions,	b. Due to (or as a conse	nuence o	fi.						
Defin ,	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,						
O, exec	an and rial-tra	Exa	resulting in death) Last	C Due to (or as a conse	equence o	r):						
. Box 68760, death certificate be executed	attending physician and for use as the burial-transit	ical		d								
× 6	ang b	Mec	IF FEMALE:	23c. If yes, outcome pf preg								
Bo eath c	attenc for us	sician/Medical	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2□Fe 4□Pregnant at time of	tal death	3 □Ectopic pregnancy 5 □ Other (specify) _	/		23d. Date of Month	delivery Day Ye <i>a</i> r		
i te	by the		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	GOZIII	one (specify)						
Records, P.O The law requires that the	been signed by should be detac	by Phy	Part II. Other significant conditions	contributing to death but not re	esulting in	the underlying cause giv	en in Part I.	23e. Did	tobacco use contribute	e to the cause of death?		
Records,	onld b							1 🔽	Yes 2 No 3□	Probably 4 Unknown		
law r	233	Completed						24a. Was	ppsv prior	e autopsy findings available to completion of cause of		
	ate pag			1				perf 1□ Yes	ormed? death			
	certificate rector, paç	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Oth	er.	eath (Check only				
P Phy	erahdi	٦	27. Manner of Death	28a. Date of Injury	28b. T	me of 28c. Injur	4 LI Nursing		how injury occurred	Specify)		
ion ath.	r: After	atio	1 Matural 5 Pending 2 Accident investigation		In		K? Yes 2 □ No					
DIVISION OF lor Attending Physicatics death.	irecto by th	Certification:	3 Suicide 6 Could not ! 4 Homicide determined	28e. Place of injury - At building, etc. (Spe	home, far	m, street, factory, office	=37		(Street and Number or own, State)	Rural Route Number,		
pital o	eral D		29a. Certifier 1 Certifying F	hysician: To the best of my k	nouledan.	don'th occurred at the fi	mo data and place	and due to the	(-)			
Div	To the Funeral Director: completely filled in by the	Medical	(Check only one)	miner: On the basis of exami and manner stated.	nation and	for investigation, in my of	opinion, death occ	curred at the time	e, date and place, and	r as stated. due to the cause(s)		
To th	ro th	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (M	onth, Day, Year)		
			8 Shirt M	D		4	21227	-	JULY 8	11,2007		
H			30. Name and address of person who		em 23a) (7		0 8	A500 A	c P	00 100		
	Sta	te.	SRIDHAR ISADU 31. Date filed (Month, Day, Year)	32. Registrar's Sig	- I was to be a second of the							
F	Registr		JUL 2 4	2007 Jesses	S.	of figures						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 200<sup>Ygar</sup> 21, Delp Lillian Μ. 4:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Riverview Nursing Home Essex Baltimore If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** Year) 1 M 2 TF Days 82 219-18-4298 Director April30,1925 Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Dundalk 1 ☐ Yes 24 No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 8348 Kavanagh Rd. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examination once. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No if Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Housewife 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret C. Roman John Frederick ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 7845 Scholar Rd. Dundalk Md. 21222 Margie Butterworth July 25 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cem. Baltimore 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of neral Service Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (dynextersia /Medical Due to ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician at s the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical almic IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been s ector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No မ 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ∏ Yes 2 ∏ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. title of certified 29d. Date signed (Month, Day, Year) 29b. Signature and 00055171 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SEBASTIAN

31. Date filed (Month, Day, Year)

IC JOHN

3023

Registrar's Signature

DHMH 17 Rev 1/2001

EASTERN AVENUE BALTIMORE

Registrar
DHMH 17 Rev 1/2001

State

HOMAS

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore UMMC If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F 52 4/22/1955 Director 215-50-8075 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Parkville Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code within 72 hours after death with 2811 Taylor Avenue Funeral 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ⊅ŌNo Specify. White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Media. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles George Dersch Virginia Jonas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Dersch/ mother 23 South Union St. Cambridge, NY 12816 20b. Place of Disposition (Name of Evans Funeral Chapel Bel Air July 23, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2☐Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licens 22. Name and Address of Facility eaceful Alternatives funeral & Cremation Ctr., P. A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Starh **Physician** Hureus days /Medical Due to (or as a consequence of): Examiner Vehic Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner A DOCKNICH APPROVED BY MEDICAL ENMINER y physician and as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical for use as the attending IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pre in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (spe signed by the a Id be detached for P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy cate has l page 2 s performed? certificate 1⊡ Yes 2 □ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ٩ 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation Subject driver in motorveluele accident 1 ☐ Yes 7/9/07 15:30 2 Accident 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Cal Street

28f. Location (Street and Number or Rural Route Number, Richard Street)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 6 Could not be determined 3 ☐ Suicide 4 Homicide 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of confifier 29c. License number 29d. Date signed (Month, Day, Year) 0542601

Registrar
DHMH 17 Rev 1/2001

State

een St Bathmore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

olom bo

32. Registrar's Signature

hristopher

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylan			t of He			Reg. I	71	0.7	23615
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last Salvatore J.	Daniele			T		Jul	J		2007	3. Time of Death 07:55 AM
	Examir	ner	4a. Facility Name (If not institution, give 1025 Genine Drive			4b. City,		ocation of De. Burni				ny of Death e Arui	ndel
	Funeral Director		5. Social Security Number 6. Se 017-03-9327	7. Age (In yrs.	last birthday) 6 Yrs.	If Under Months	r 1 Year	If Under 24 H		te of Birth onth, Day, Yea			lace (State or Foreign try)
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show says injury or other traumatic event, the Medical Examinat must be notified at ance.	Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Anne Ar  10e. Street and Number  1025 Genine Drive	unde1	y, Town or Lo	10f. Zip	Code	Burni 21060			Ų.	What Coun	
980	ours after de ral', or Itsm Examiner o	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?  1		Was Dece If Yes, spe 1 ☐ Yes		panic Origin? Mexican, Pu Specify:	(Specify Ye ierto Rican, (	etc.)		ice - Americ ack, White, ify: Wh	
21215-0036	within 72 ho ane. than "natu	mpieted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		life.		rk done du se retired)	ion ring most of v	working			Business/ind	
	uld be fitled Mental Hygir rked other tilc svent, L	To Be Co	17. Father's Name (First, Middle, Last)	Daniele	11	acliii		8. Mother's N		Middle, Maid Cugn	len Suma		Tilly
e, Mary	is 1 and 2 sho of Health and N Itsm 27 Is ma other trauma		19a. Informant's Name/Relationship (T) Dora K. Gustafson	(daughter)	102	5 Gen	ine D		alen B	Number, Cit urnie	MD 2	21122	
Baltimore, Maryland	permit. Pages 1 Department of H Importent: If Its eny injury or ot once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	temoval from State	Place of Disponentery, creations C	matory or o emete 2. Name ar	other place) Py nd Address	of Facility	Date 1y 27 2007 Stall	Ha ings F	verh unera	ill. Mall Hor	lass. ne. P.A.
	Physician /Medical Examiner		Sequentially list conditions,	Due to for as a conseq	uence of):	er the mod				Pasadi ratory arrest,	ena,		Approximate Interval Between Onset and Death Onset Approximate
8760,	Attending Physician: The law requires that the death certificate be executed rideath.  rideath.  sctor: After this certificate hes been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	edicai Examiner	day, Jading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
P.O. Box 6	that the death certificated by the attending placed by the attending placed for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pi Other (sp	regnancy pecify)					ate of delive onth	ry Day Year
Records, P	w requires that been signed t should be det	þ	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	nderlying o	ause given	in Part I.	23	e. Did tobacc			e cause of death? ably 4 □Unknown
al Kec	ding Physician: The law in After this certificate hes but funeral director, page 2 st	e Completed	25. Was case referred to medical						1	a. Was an autopsy performed? Yes 2	?	prior to con death?	osy findings available npletion of cause of 2 No
5	ysicia s cert direct	To Be	avaminar?	fospital: 1   Inpatient 2	ER/Outpatier	nt 3 🗆 DO		26. Place of D		k only one) Hesidence	6 □Ot	her (Snecifi	4
Division of Vital	ending Pheath.	ertification: 1	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury a Work?	s 2□No		scribe how in			,
$\leq$		O	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify sician: To the best of my kno	Y)			date and at	City	y or Town, St	ate)		Route Number,
	To the Hospital or within 24 hours after to the Funeral Director Completely filled in	Medical	(Check only one)  29b. Signature and title of certifier	ner: On the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	vestigation	. License	number	ccurred at the	e time, date a	and place	, and due to ed (Month, l	the cause(s)  Day, Year)
)	0		) Gonathun	James O	MI	D	001	-384		7/	17/	200	7
1	+1 V		30. Name and address of person who co Jonathan Formun  31. Date filed (Month, Day, Year)	In D	1 23a) (Type,	Print) Field	Res	te: A	Glan	Burn	lie	MD	2106
	Sta Registr		JII 9 4 200		L A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Ruth Parlie Elliott 07 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rose da Le

If Under 1 Year | If Under 24 Hrs.

Adopths | Days | Hours | Min. - Min Square Social Security Number 0 6. Se timore Date of Birth (Month, Day, Year) 11/08/1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 220-30-3457 1 □ M 2√2 F 72 Director Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Essex Director 1 ☐Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Homberg Avenue 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 → No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Furniture Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Cabinet Makers Helper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Wishon Maggie Earls 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21210 Diane Langston - daughter 6109 Bellinham Court Apt. 1132 Baltimore, Maryland Important: If Item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State Bayview Crematory Ind 07/23/07 Baltimore, Maryland Donation 5 ☐ Other (Specify) ature of Funeral Service Lice see 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Maryland 21221 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a Pa 1. Enter the disease, or com shouk, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final diseas) of condition resulting in death) **Physician** Huponemia Que tor as a consequence of): 24 hours /Medical Examiner neymonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Physician/Medical Exam that initiated events resulting in death) Last Due to (or as a consequence of): as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by lung cancer liver metastasis 1 Yes 2 No 3 Probably 4 Unknown Staph aureus Resistant bacternia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 **1** No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury ours after death.
neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

9000 Franklin Square Drive Baltimore, Nd 2/237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Williams

32. Registrar's Signature

11/1/20

Cassandra

Year)

31. Date filed (Month, Day, Yea

			1 - For State Registrar	te of Maryland / Do	epartment o			ienė () () 7	23518
11 30	Dhusia		1. Decedent's Name (First, Middle, Last)				2. Date of Deat	th	3. Time of Death
	Physic /Medi		Anna D. Ehrenfri	ed				17 2007	5:10am
P.	Exami	ner	4a. Facility Name (If not institution, give street a			m, or Location of	Death	4c. County of Death	
	4		Heritage Center  5. Social Security Number 6. Sex	Genesis 7. Age (In yrs. last birth)		imore	4 Hrs. C. Dans of Birth	County	
	Funeral Director		162-01-2121		Months Da	ays Hours	4 Hrs. 8. Date of Birth (Month, Day, June 26	Year) 9. Birthp Court PA	lace (State or Foreign ntry)
	P .		Usual Residence of Decedent				0 4110 20	71313 111	
	anylar show	5	MD Baltimore	10c. City, Town	r Location Cimore			1	0d. Inside City Limits
	the N	Director	10e. Street and Number	Dari		4-			1 ☐ Yes 2 No
	3a or		311 Pinewood Roa	đ	10f. Zip Coo		11	0g. Citizen of What Coun	itry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show that the Madical Exartine rusal be notified at	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S.	13. Was Decedent	of Hispanic Origi	n? (Specify Yes or No-	14. Race - Americ	an Indian,
9	or Ite	/Fu	1 Never Married 2 Married 1	ed Forces?  Yes 2© No es, Give	If Yes, specify (		Puerto Rican, etc.)	Black, White,	
ğ	hours ural',	d by	3 Mildowed 4 Divorced Yea	r or Dates:				Specify:Whit	-e
21215-0036	in 72	Completed	15. Decedent's Education (Specify only highest grade comp.	leted) (C	ecedent's Usual Oc Give kind of work do fe. DO NOT use re	one durina most d	of working	16b. Kind of Business/Inc	dustry
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	be filed htal Hyg od othe event,	Bec	17. Father's Name (First, Middle, Last)			18. Mother	s Name (First, Middle, N	Naiden Sumame)	
<u>S</u>	should be nd Mental marked o	10	Edwin Shaw			unkn	own		
Maryland	and nand		19a. Informant's Name/Relationship (Type, Prin					City or Town, State, Zip	
	1 and Health em 27 ther tr		Edwin Ehrenfried  20a. Method of Disposition	20h Place of D	enocition (Alama o	4	Data	ore MD 212	
و	Pages nent of int: if its iry or o		1 Surial 2 Cremation 3 Removal	from State Holly	crematory or other Hill Ce	place) Meterv	7/19/07	20c. Location - City or To Baltimore	wn, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Exp. direct must be nutitied at annex.		4 Donation 5 Other (Specify)  21. Signature Funeral Funce Linese	11	22. Name and Ad				
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	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause	that caused the death. Do not	enter the mode of	dying, such as ca	ardiac or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ORONAR	YAK	TEK	Y DIS	EASE	Orset and Death R
	/Medical Examiner		resulting in death)	ue to (or as a consequence of):	Lai	1187	Ar Detr	100	1
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4	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	20 10 (01 23 2 00/1364261106 01).		(			l
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X O D	attend for us	Physician/Me	in the past 12 months?		3 Ectopic pregna			23d. Date of delive Month	ry Day Year
j.	the d	yslo		Pregnant at time of death Unknown	5 ☐ Other (specify,	)			,
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cords,	equire en sig ould be						1 ☐ Ye	s 2 to 3 Proba	ably 4 Unknown
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<u> </u>	ician: Sertific ector,	Be	25. Was case referred to medical examiner?			A /	Death (Check only one		
5	Phys r this ral dir	2	1 ☐ Yes 2 ☐ Hospital:  27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpa Date of Injury 28b. Tim	tient 3 DOA			nce 6 Other (Specify	)
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2	rs afte rs afte al Dir ed in	Certification:	4 THOMICOS	building, etc. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Medical	Z Medical Examiner: On	o the best of my knowledge, do the basis of examination and/o	eath occurred at the	time, date and p	place, and due to the cau	use(s) and manner as sta	ated.
	thin 2 the o the omplet	Med	one) and 29b. Signature and title of certifier	manner stated.		ense number	200		
	- ₹ ⊢ 8		· days -th	my m	290. 1	5 121	160	d Date signed (Month, D	O O
		-	30. Nimb and address of person who completed	cause of death (Item 234) (Ily)	ne.Print)	LIO	RITAI	117/ 1170	History
	5		MAKULISI	DE M	TRUI	ANDA	1 1-61 06	TIE ITIG	MANTA
	Sta	-	31. Date filed (Month Day, Year)	32. legistrar's Signature	1	+ ) 1 ~ L	1-6-12	3	
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			1 - For State of Maryland / Dep	artment of Health and M rtificate of Death	ental Hygie	L. U / i	23619
	Physic	ian	1. Decedent's Name (First, Middle, Last) ADOL PHUS W. EMMONS		2. Date of Death Month	Day Year	3. Time of Death 8:23 AM
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 5743 EDMONDSON	AVE	4c. County of Death  ALTO. MI	21228
*	Funeral Director		5. Social Security Number  6. Sex 12. M 2 F  7. Age (In yrs. last birthday) 12. F  7. Age (In yrs. last birthday) 12. F  94  94  95. Social Security Number	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Ye Mar. 14,	9. Birthpl 1923 Vir	ace (State or Foreign ry) ginia
	ryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L				d. Inside City Limits
	the Ma 28a-f s	recto	MD Baltimore  10e. Street and Number	Catonsville	10a	Citizen of What Count	1 Yes 2 No
	23e or	al Di	218 Rolling Brook Way	21228		nited Stat	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show wenty injury or other treumatic event, it is Madical Exertination on price.	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 🖁 No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whi	tc.
Maryland 21215-0036	f within 72 ho liene. r then "natur tr e Medice.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation I kind of work done during most of workir DO NOT use retired)  Legal Clerk	B B	saltimore C Sircuit Cou	ity
and	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name Irene 1	(First, Middle, Mail	,	5. 5.5
	nd 2 shoulth and M		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural Rolling Brook Way			*
altimore,	Pages 1 and neut of Healint: If item	,	20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  3 □ Removal from State	osition (Name of Di matory or other place)	ate 200	c. Location - City or Tov	vn, State
Baltir	permit. F Departme Importan eny injur	(	figure 1 Funeral Service Licens 2	ark Cemetery 7-23- 2. Name and Address of Facility Ambr	ose Fune		Inc.
H			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	1328 Sulphur Spring ter the mode of dying, such as cardiac or			ZIZZ/ Approximate Interval Between
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I a	icien: Th certificate rector, pag	a)	25. Was case referred to medical	26. Place of Death	1□ Yes 2₽		P□ No
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NISION (	ding I h. After funer	atlon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)	28c. Injury at Work?  M 1   Yes 2   No	8d. Describe how i	njury occurred	
Ž	i gifte	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	8f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
	To the Hospitel or Ai within 24 hours after or To the Funerei Direc completely filled in by	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, at vestigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
	To the within to the comp	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, D	
,	15		Mercal productions of death (for 330) Tura	1766)	0	7-19-2	207
_	1 '		30. Name and address (person who completed cause of death (them 23a) (Type, Helical Current 730 Little	Proling + 508 Gle	adrie,	19072 PM	
	Sta Registr	100	31. Date filed (Month, Day, Year)  JUL 2 4 2007  32 Negistrar's Signature	will			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:48 PM para /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist HOSPICE lowsor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 □ M 2 💢 F 215-30-6803 Director Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eatth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5/ 21236 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Whi by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical Wienberg + Elementary/Secondary (0-12) College (1-4or 5+) secretar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Pickens Court C. Farley Baltimore Maryland 21236 - daughte 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden's Of Faith 20c. Location - City or Town, State 20a. Method of Disposition 3 □Removal from State 1 ☑Burial 2 ☐ Cremation 120/07 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Evans Funeral Chapel & Cremation Syr-Parkville 21. Signature of Funeral Service Licens 8800 Harford Road Parkville Maryland 23a. Part1. Enter the disease shock, or heart failure. I eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ma resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2□ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ٩ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 Tes 2 🗌 No death. 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital To the Hospital or within 24 hours at To the Funeral D

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of feath (Item 23a) (Type, Print) BM( 6701 32. Registrar's Signature 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Time of Death

9. Birthplace (State or Foreign Country) Vest Virginia

10d. Inside City Limits

Approximate Interval Between Onset and Death

entur

Year

Day

3 Probably 4 □Unknown

1 □Yes No

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Year

West

Black. White, etc.

White

Baltimore

2007

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician:

Certification: 1 Natural (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Good **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 7 Day Thomas Robert Fields 9:33 P.M 20 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Timonium Baltimore Stella Maris Hospice If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) tX M 2 ☐ F 85 Yrs 212-18-8815 9/27/1921 Balt., Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXXI Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8303 Alston Road 21204 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. No If Yes, Give Year or Dates: 1 ☐ Never Married 🍇 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 National Brewing Comp. Brewmaster 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Fields Margaret Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Fields/ spouse 8303 Alston Road Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State July 24, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A 21. Signature of Funeral Service Licensee 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Pal 11. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Year Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2**X** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 🙀 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Division or Vital Records, P.O. Box 68760

within 24 hours after death **To the Funeral Director:** , сотрletely filled in by the f

State Registrar

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Directo

Funeral

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Completed

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Examine

Physician/Medical

Completed by

Be

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Certification:

Medical

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

**Physician** 

/Medical

Examiner

attending physician and for use as the burial-tran

nis certificate has director, page 2 :

Baltimore, Maryland 21215-0036

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

2300 DULLANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

# Baltimore, Maryland 21215-0036

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	Exa	iedi amlı
	6	
Division or Vital Records, P.O. Box 68760,	Ital or Attending Physician: The law requires that the death certificate be executed	ral care upon.  ral Director: More this certificate has been signed by the attending physician and also the trief that the things and the trief that the things are the trief that the trief the trief that the trief th
or Vi	Physicia	this cert
Division	ital or Attending I	ral Director: After

		1 - For State Registrar	State of	f Marylan			of Health of Death		lental Hyg	jiene leg. No.	017	23624
Physicia /Medic		1. Decedent's Name (First, Middle Ruth Eva Frank	, Last)						2. Date of Dea Month July 1	Day	Year	3. Time of Death 6:30 A M
Examin		4a. Facility Name (If not institution Gilchrist	, give street and nur	nber)		Towsor		of Death			unty of Deat altimo	
Funeral Director		5. Social Security Number 219–22–7434	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Months E	Year If Unde Days Hours		8. Date of Birth (Month, Day) Feb. 4	, Year)	9. Birt Co MI	hplace (State or Foreign untry) )
e Maryland a-f show lifled at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Balti	more	10c. Cit	y, Town or Lo						10d. Inside City Limits 1 □Yes ♣ No	
ath with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 14213 Manor Rd.				10f. Zip C	21131				of What Co	USA
permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: I fleem 27 is marked other than "natural" or items 23a or 28a-f show important: If them 27 is marked other than "natural" or tems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status  1 □ Never Married 2 □ Marri 3 双 Widowed 4 □ Divorced	Armed Fo	<sup>2</sup> ₩ No	1	Was Deceder If Yes, specify 1 ☐ Yes 2🎇			ecify Yes or No- Rican, etc.)		Race - Ame Black, White ecify:	
ithin 72 hou ne. nan "nature Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1	-4or 5+)	(Give	dent's Usual ( kind of work of DO NOT use	done durina mo	ost of worki	ing	16b. Kind	of Business/	Industry
I be filed w ntal Hygier ed other th event, the	Be	12 17. Father's Name (First, Middle,			Home	maker_	_		(First, Middle,			
nd 2 should lith and Me 27 is mark r traumatio	ဥ	Benjamin Christ  19a. Informant's Name/Relationsh  Mary Prime/daug	nip (Type. Print)	an				ber or Rura	a Hannil al Route Numbe			Zip Code)
Pages 1 ar rent of Hea nt: If item 3 ry or other		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S)	3 ☐Removal from	State	Place of Disponentery, cre-	sition (Name matory or othe	of er place)		Date	20c. Locati	ion - City or	
permit. Departm Importal any Inju		21. Signature of Funeral Septice			2: I	2. Name and A	Address of Faci Funeral	llity L Home	e of Dul Timoniu	Laney	Valle	y, Inc.
Physician /Medical Examiner ijal-transit	Examiner	23a. Par1. Enter the disead shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Se Due to b. Due of c.	aused the deat ach line.	quence of):  Com quence of):		of dying, such a	as cardiac o	or respiratory an	rest,		Approximate Interval Between Onset and Death WWKS
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 1% months? 1 ☐ Yes 2 M No 9 ☐ Unknown	4□Pregr 9□Unkno	lirth 2 ⊡Feta ant at time of d own	al déath 3E death 5E	⊒Ectopic preg ⊒ Other (spec	sify)				. Date of del Month	Day Year
w requires that the debeen signed by the should be detached	by	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cau	se given in Part	· I.	23e. Did to		14	o the cause of death?  robably 4  Unknown
n: The law ricate has be	Completed								24a. Was a autop perfor 1∐ Yes	sy		utopsy findings available completion of cause of 2 No
To the Hospital or Attending Physician: Th within 24 hours after death.  To the Funeral Director. After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1										city) hosfice
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: K completely filled in by the fr	edical Cer											
To the within To the comple	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month,  D 58303									h, Day, Year)		
5		30. Name and address of person	who completed caus	e of death (Iter	N/ C	MANUS	est Po	NUCN	no :	21204		·
Sta Registr		31. Date filed (Month, Day, Year)	32. R	egiatrar's Signa	ature	Goods	,					

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

State Registrar

Medical

29b. Signature and title of certifier

29c. License number  $\infty 36112$  29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll Medical Group 4231 Northwoods Trail Hampstead, Not 21074 D.A. Rocha MD

1 Ncertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year)

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William A. Giannuzzi, Jr. 1- For State Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 13, 2007 Year William Anthony Giannuzzi 0610 hrs **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore St. Agnes Hospital N/A If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** oreign Country) MD Months Days Hours Director 218-02-8079 31 Dec. 7, 1975 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Catonsville Yes 2 X No MD Baltimore or items 23a or 28a-f show notified at once. Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 21228 25 Poplar Avenue United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 2 X Married 1 Never Married Yes If Yes. Give Year 1 Yes 2 X No specify: White 3 Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical Baltimore, MD 21215-0036 Installer Office Furniture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Anthony Giannuzzi Victoria Anne Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vicki L. Giannuzzi - Wife Catonsville, MD 21228 25 Poplar Avenue, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Wesit Arundel Burial 2 Cremation 3 Removal from State 7-16-2007 Odenton, MD Other Specify Crematory 122 Name and Address of Facility Am rose Funeral Home, Inc. uneral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Heroin intoxication taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED #1,23a,27,28a-f,perME,C869, 7/31/07 TT attending physician or use as the burial Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Year Ectopic pregnancy Day Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been sector nage 2 should 24a. Was an 24b. Were autopsy findings available #1-Name-Jr autopsy prior to completion of cause of performed? . death? 2 No ✓ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification:

of Vital Records, P.O. lospital or Attending Physician: Director: hours after Funeral D

Fo the within To the Comple	dic	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.	or
F * F 3	Me	29b. Signature and title of certifier	
07		30. Name and address of person who completed cause of death (Item 23 Ling Li, MD Assistant Medical Examiner 111 Personal Ling Li, MD Assistant Medical Examiner 111 Personal Ling Li, MD Assistant Medical Examiner 111 Personal Ling Li, MD Assistant Medical Examiner 111 Personal Ling Li	
S Regis	tate trar	Mar. Mar.	,

Natura

Accident

Suicide

Homicide

2

3

Pending

6 X Could not be

Investigation

determined

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 gistrar's Signature

(Specify) found at residence

Fnd 7/13/2007

Fnd 5:00 am

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc.

1 Yes 2 X No

29c. License number

O.C.M.E.

unk

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

4777 Drayton Green, Baltimore, MD

July 13, 2007

07-05120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Clarence Gaskins 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 4, 2007 1505 hrs **Medical Examiner** Clarence Jimmy Gaskins 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince Georges Hospital Center Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or November 8 Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months Country) DC Director 1956 578-76-2401 50 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 X Yes 2 No 23a or 28a-f show notified at once. DC Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code the 1 774 Kennilworth Terr NE # 20019 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 2 X Married Never Married Yes Specify: Black Widowed Divorced If Yes, Give Year Yes 2 X No specify: ò 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) h and Mental Hygiene. 27 is marked other than "n nmatic event, the Medical E College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 21215-0036 Private 11th Barber 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roosevelt Gaskins Sorrell æ Alice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ortant; If item 27 is may or other transatic e Glover St. Washington DC 20018 Shirleeta J - Daughter 1837 Otis NE. 20b. Place of Disposition (Name of cemetery, July Date 14 20c. Location - City or Town, State 20a Method of Disposition timore, crematory or other place) Burial 2 X Cremation 3 Removal from State Beltsville, Md Chesapeake Crematory 2007 Donation 5 Other Specify 22. Name and Address of Facility D.L. McLaughlin Funeral 21. Signature of Funeral Service Licensee 2019 MLK JR Ave, SE Washington DC 20020 10 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Heroin and cocaine intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last that the death certificate be executed Physician/Medical X UNPENDED AMENDED #23a,27,28a-f, perME,g869, 7/25/07 TT attending physician or use as the burial Box 68760. 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Ş Yes 2 No 3 Probably 4 ✔ Unknown Records, P. Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy The law 1 certificate has death? performed' 2 No Yes Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other<sub>4</sub> Hospital: 1 examiner? Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA this 1 ✔ Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death the Hospital or Attending Certification Natural Yes 2X No Pending within 24 hours after death.

To the Funeral Director: Director: d in by the f Fnd 7/4/2007 Fnd 1:54 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide 774 Keniworth Ter. N.E. Apt 1 determined (Specify) found in residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 5, 2007 O.C.M.E. 2 Pind Huna Massel 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month, Day, Year) 2 32. Registrar's Signature Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0647 7.0 2007 ba In tano stian /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Himore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Davs Hours 1 ☑ M 2 □ F 63 5-12-1944 Italy 047-34-3841 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~-." any injury or other traumatic event. 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 1 ☐ Yes 2 No MS Hinds Jackson Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 39211 USA 11 River Run Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: white Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Home Builders Elementary/Secondary (0-12) College (1-4or 5+) Building Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fontana Nella Philip Giurintano 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 39211 St. Andrews Dr., Jackson, MS Mr. Leo Giurintano 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkway Memorial Cem. 7-24-2007 Jackson, MS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. nature Funeral Se vice Liconsee Singleton Funeral Home P.A. M01364 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Second Ave SW Glen Burnie MD 21061 Approximate Interval Between Onset and Death Immediate Cause (Final Se veeks **Physician** disease or condition resulting in death) /Medical Due to ( as a consequence of) Examiner Endocardition Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown рееп 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 autopsy page The perform certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? After Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certifier

20

State Registrar MULLIK

Registrar
DHMH 17 Rev 1/2001

MAJMUDAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL DOCTOR

RES-000

20,

Hospitel 600N Wolfe St. Bultimore MD 21287

2007

Physician (Medical Examiner  Frameral Director   Scarol Lynn Hart   Sand Road   Scorol Security Name (I'ne institution, give street and number)   Scorol Security Name (I'ne institution, give street and number)   Scorol Security Name (I'ne institution, give street and number)   Scorol Security Name (I'ne institution, give street and number)   Scorol Security Name (I'ne institution, give street and number)   Scorol Security Name (I'ne institution, give street and number)   Scorol Security Name (I'ne institution, give street and Number)   Scorol Security Name (I'ne institution, give street and Number)   Scorol Security Name (I'ne institution, give street and Number)   Scorol Security Name (I'ne institution, give street and Number)   Scorol Security Name (I'ne institution, give street and Number)   Scorol Security Name (I'ne institution)   Scorol Name (I'ne institution)   Scorol Security Name (I'ne institution)   Scorol Name (I'ne institution)   Scor	1	State Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No.	,	3. Time of Death				
4. Scripting first instance, per street and numbers  6. Colly From, to Location of Death  Coccil  Function  Formation  Seed 15 King first p 1 sland Road  Formation  Seed 16 S							Month	Day		
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Source Security Number 2 -	aminer 4	4a. Facility Name (If not institution, give si	reet and number)							
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Mile   Cecil   Earleville   100, Street and Number   100, Citizen of What Could   11, Marcel Status   11, Ma	, F		10c. (	City, Town or Lo	ecation					10d. Inside City Lim
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College (1-4or 5-)   Norman services   Norman			L.I.	Ları						
College (1-4or 5+)   Nomemaker   Own home   Nomemaker   Own home								10g. Citize		intry?
College (1-4or 5+)   Nomemaker   Own home   Nomemaker   Own home	1 10	645 Knights Island	l Road							
College (1-4or 5-)   Normal are remoted   Normal	E e	11. Marital Status		U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	14		
College (1-4or 5-)   Normal are remoted   Normal	됩		1 □Yes 2 No							nite
College (1-4c 5+)   Coll	a a	3	Year or Dates:							
College (1-4of 5+)   College	e te	15. Decedent's Educ	ation completed)	16a. Dece	dent's Usual Decupa	ation during most of work	ina	16b. Kind	d of Business/li	ndustry
17. Father's Name (First, Middle, Machen Surmane)   18. Mother's Nam				life.	DO NOT use retired	1)				
17. Father's Name (First, Middle, Ascien Sumane)   18. Mother's Name (First, Middle, Ascient Sumane)   18. Mother's Name (First, Middle, Name	ا <u>ا</u> ا	unk ur	k	hoi	nemaker			own	home	
WILLIam Frank HOTIman SY  WILLIam Frank HOTIman SY  199. Informants name/heliatoniching (Prop. Prot)  Ratheryne Hart/daughter  199. Informants name/heliatoniching (Prop. Prot)  Ratheryne Hart/daughter  101 Morgnec Road #B204 Chestertown, MD  102. Method of Disposition  1	Se C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Si	umame)	
198. Informatic Name/Relationship (Type, Print)   199. Mailing Address (Street and Number or Rural Fourte Number, Gry or Town, State, 21   190. Marging Co. Chestertown, MD   200. Method of Disposition   200. Place of Disposition (Name of Committee), 200. Pla		William Frank Ho	ffman Sr			Alice Ka	theryne	e McLa	ane	
Continue   Continue	E C	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Numb	er, City or T	Town, State, Zi	p Code)
Continue   Continue		Katheryne Hart/dau	ighter	101 1	Morgnec R	oad #B204	Cheste	ertown	n, MD	21620
Committee   Comm	<b>e</b> 2	20a. Method of Disposition	206	. Place of Dispo	sition (Name of		Date	20c. Loca	ation - City or T	own, State
23a Part1. Enter the disease, for complications that caused the death. Do not enter the mode of tyring, such as cardiac or respiratory arrest, immediate Cause (Final countries).			moval from State	cemetery, crei	natory or other plac	(a)				
23a Part1. Enter the disease, for complications that caused the death. Do not enter the mode of tyring, such as cardiac or respiratory arrest, immediate Cause (final minder later cause on each line).	돌.		<u> </u>	1 00	Name and Address	an of Families				
23a Part1. Enter the disease, for complications that caused the death. Do not enter the mode of tyring, such as cardiac or respiratory arrest, immediate Cause (Final course) and the properties of the properti	DC DC	21. Signative of European Service Sicentia	ad s Virecto	or St	tate Anat	omy Board	655 W.	Balt	imore	Street
shock for heart failure. List only one cause or each line.  Immediate Cause (Final disease or conditions contributing to death)  Sequentially list conditions, and cause in the lime death of the standard of		Juny //1	<u></u>						-	
disease or conditions are consistent of the control		23a. Part1. Enter the disease, or complic shock for heart failure. List only on	ations that caused the de e cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause given in Part I.    IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   1   1   1   1   1   1   1   1   1	ian	Immediate Cause (Final disease or condition	MPta ST	atic	100	inama	4			mo
Sequentially list conditions, if any, leading to mindrate cause. Enter Underlying that initiated events resulting in death) Last    Due to (or as a consequence of):	Cai	resulting in death)	Due to (or as a cons	equence of):	(ani	11.00	/			1. (0
Due to (or as a consequence of):    Due to (or as a consequence of):		D	-Tobal	00	Abuse					
Due to (or as a consequence of):    Cause Upsages or Injury hat mitated events resulting in death) Last   Due to (or as a consequence of):	Je J	if any, leading to immediate	Due to (or as a cons	equence of): /						
Section   Sect	ansi ansi	that initiated events								
Part	EX I	resulting in death) Last	Due to (or as a cons	equence of):						
	ca la	<b>€</b> d								
	ed as									
in the past 12 months?    The past 12 months?   The past 12 months								23	ld. Date of deliv	/erv
Part II. Other significant continuous contributing to dearn but not resulting in the directlying cause given in Part II.    1   Yes 2   No 3   Pro	c a	in the past 12 months?							Month	Day Year
Part II. Utiliar significant continuous contributing to death of the stuffing in the underlying cause given in Part II.    1   Yes   2   No   3   Pro	rysi									
So to the state of		Part II. Other significant conditions con-	ributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	e contribute to	the cause of death
24a. Was an autopsy performed? 1   Yes 2   No   1   Yes   2   No   No   No   No   No   No   No	8 6	Chronic OBSTRUE	TIVE PUL	MONIAN	V Dist	15F	10	Yes 2 🗆	No 3∏Pro	bably 4 Unkn
autopsy performed?   1   Yes 2   7No	e e e	alotano C	1000	2.1.01	VIJ.CI					
25. Was case referred to medical examiner?    1	2 du	UPSIKU(TIVE SE	LEP MI	UEA			auto	osv	prior to c	opsy findings avail: ompletion of cause
25. Was case referred to medical examiner?    1	og O	HYPERTENSION	$\checkmark$							2□ No
1   Yes   2   No	ō 0 :			1/2		26. Place of Deat	h (Check only o	one)		
27. Manner of Death   Natural   2   Accident   3   Suicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rur City or Town, State)		H	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursing Ho	me 5 Aesi	dence 6 [	☐Other (Spec	ify)
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Run City or Town, State)  29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	75		28a. Date of Injury	28b. Time o	f 28c. Injun	y at	28d. escribe	how injury	occurred	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, one)	를 다		(Month, Day 1 day)	Injury						
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month,	₹ <b>2</b>	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, sti	reet, factory, office				Number or Rui	ral Route Number,
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month,	i ta	4   Homicide	building, etc. (Spe	cify)		1	City or To	w⊓, State)		
Denbara a lacey no 025915 7-18-6		29a Certifier 1D Certifying Phys	ician: To the best of my k	nowledge deat	h occurred at the tin	ne date and place	and due to the	cause(s) a	nd manner as	stated
Denbara a lacey no 025915 7-18-6	dica	(Check only 2 Medical Examin	er: On the basis of exami	nation and/or in	vestigation, in my o	pinion, death occur	red at the time,	date and p	lace, and due	to the cause(s)
Delara a lacey no 025915 7-18-6	Me A	29b. Signature and title of certifier	und marrior stated.		29c. License	e number		29d. Date	signed (Month	Dav. Year)
20 Name and address of passon who completed garse of death (fleet 22a) From Paint)	8		1. /	/		5011			15-	47
30 Name and address of person who completed cause of death (Item 23a) (Time Brief)		Duvara	U /all	Ly M	1 Vo	13915			-15-0	
		/	/			-				
Barbara Parey 111 West High St. Suite 214 Elkton, Md. 21921		Barbara Parey 111	West High St.	Suite 21	4 Elkton, M	fl. 21921				

DHMH 17 Rev 1/2001

Rec'd 7/18/07 @

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:29 AM 2007 \*/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Mercy Medical if Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1**X**M 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1XYes 2 No Funeral Director MARY AND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 14. Race 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: ò 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau BALTO, MD, 21209 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition 1 Boxial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) BALTIHORE, MD BROWN JR. FUNERAL HOME e of Funeral Service Licensee 2 Signatu BALTO. MD. 21217 art1. Epier the disease, or complications that caus shock, or neart failure. List only one cause on each Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, invediate Cause (Final disease or condition resulting in death) Small Cell **Physician** months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by um Difficile Infectious 1 | Yes 2 | No 3 | Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dictornoletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06466 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 St. Paul B lace, baltimore, maryland 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

		•	1 - For State Registrar	tate of Man		artment of Hertificate of L		Mental Hygie	1.001	23631	
- A. C.	Physici /Medic		1. Decedent's Name (First, Middle, Last)  John Esten Haviland					2. Date of Death Month July 18,	Day Year 2007	3. Time of Death 4:52 a M	
-	Examin		4a. Facility Name (If not institution, give stre Gladys Spellman Specialty		nd Nursing	4b. Cily, Town, or Cheverly		h	4c. County of Death Prince Ge		
4.	Funeral Director		5. Social Security Number 6. Sex 1 12 M	- 0 -	n yrs. last birthday 4 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Feb. 08,	'ear) Co	hplace (State or Foreign buntry) sachusetts	
	aryland show	٥٢.	Usual Residence of Decedent  10a. State  10b. County  MD  Prince Georg		oc. City, Town or the Creenbelt					10d. Inside City Limits 1 ☐ Yes 2 XNo	
	with the M s or 28e-f	Directo	10e. Street and Number 8675 Greenbelt Road		reemer	10f. Zip Code 20770		10g US	. Citizen of What Co	1.	_
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other traumatic event. The Madical Exactli at Iranii Le Indillied at ADEE.	by Funeral Director		Was Decedent Eve Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No-	14. Race - Ame Black, White Specify: Wh	e, etc.	
21215-0036	within 72 hour ane. than "natural	Completed t	15. Decedent's Educati (Specify only highest grade co	on	(Giv	edent's Usual Occupa e kind of work done o DO NOT use retired	during most of wo.	rking	Sb. Kind of Business/		_
	should be filed within and Mental Hygiene.  marked other than " umatic event, Ine Me	To Be Co	17. Father's Name (First, Middle, Last) Clarence W. Haviland	<u> </u>	110 0411		18. Mother's Nai	me (First, Middle, Ma			_
Maryland	ind 2 shou alth and M 27 Is mar er traumat	1	19a. Informant's Name/Relationship <i>(Type</i> , Judith Messinger / S		4	•		ural Route Number, C m Coast, I		Zip Code)	
altimore,	Pages 1 a lent of Hei nt: If item ry or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	20b. Place of Disp cemetery, cr Metro Cr	ematory or other plac		Date 20	oc. Location - City or atonsville		
Balti	permit. Departm Importe eny inju		21. Signatur of Funeral Service Licensee	- /	1809,	22. Name and Address	ss of Facility ufman Fu	neral Home vd., Elkri	e at MMP,	INC.	
8760,	Physician /Medical Examiner pursition and pursition and pursition is the pursitional fluority for the pursition of the pursit	cai Examiner	23a. Part1. Enter Me disease, or complicat shock, or bear failure. List only one of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	ause on each line.	scherch consequence of):			an Dife		Approximate Interval Between Onset and Death	
P.O. Box 68	death certif e attending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of 1 Live birth 2 4 Pregnant at tin 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of dei Month	livery Day Year	
	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions contrib	outing to death/but	not resulting in the	underlying cause giv	en in Part I. WCTUP			o the cause of death?	
Vital Records,	The la ete has page 2	Completed	Thrombocytop	uemies /-	1 Rene	leasitus	vicer	24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of	
	Physician: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2	pital: 1 Inpatient	2 ☐ ER/Outpati	ent 3 DOA Oth	or	ath_(Check only one) Home 5□Residen		əcify)	_
Division of	ding After fune		2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time Injury	Wor	yat k? Yes 2 □ No	28d. Describe how	injury occurred		
Divis	tel or Attenders after deatles birector: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, : (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,	
0)	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examiner		xamination and/or	investigation, in my o	pinion, death occ	urred at the time, dat	e and place, and due	e to the cause(s)	
	within 2 To the	Σ	29b. Signature and title of certifier	Devo	re am	29c. Licens			d. Date signed (Moni		
	10		Paul A. DEVOR	eleted cause of dea	th (Item 23a) (Typ	e, Print) V. ELNS SVI	y Rel F	battsi	He Mb .	20781	
10	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	pode					

			For State Registrar	State of Marylar		artment rtificate			Mei		giene Reg. No.	20	17	235	30
	Physici /Medio		1. Decedent's Name (First, Middle, Last Paul C. Hest						2.	Date of Dea Month 07	ath Day	ó	Year 2007	3. Time of Dea	h M
	Examin Funeral Director		4a. Facility Name (If not institution, give Franklin Squar 5. Social Security Number V 6. St. 213-46-0112	e Hospital Co	enfer last birthday) Yrs.	Po If Under 1	sec	ocation of De	rs. 8.	Date of Birt (Month, De)	h	Bal	Cour	lace (State or For	reign
	Maryland -f show ited at	tor	Usual Residence of Decedent		ty, Town or Lo						10d. Ins				nits No
	h with the 23a or 28a st be notii	al Direc	10e. Street and Number 424 Delaware	Avenue		10f. Zip 0	1221				10g. Citiz		/hat Cour	ntry?	
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates:		Was Decede If Yes, specif 1 ☐ Yes 2	y Cuban,	oanic Origin? , Mexican, Pu Specify:	(Specify erto Ric	y Yes or No- an, etc.)			k, White,	an Indian, etc. iite	
21215-0	d within 72 ho giene. r than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed)  College (1-4or 5+)	(Give	dent's Usual- kind of work DO NOT use	done du retired)	ring most of v	vorking				siness/Ind	e Count	У
r, ro	should be filed ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Charles Heste	2			1	8. Mother's N May		irst, Middle, yder	Maiden	Surnam	e)		
Mar,	1 and 2 sho Health and tem 27 Is me		19a. Informant's Name/Relationship (1 Mary A. Hester	/wife	424	Dela	ware	Aver	nue	Balt	imo	re 1	MD 2	21221	
ਸ਼ੁਲ Baltimore,	t. Pages 1 rtment of H rtant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Denation 5 ☐ Other (Specification)	Removal from State Ga	Place of Dispo cemetery, cres rdens	of F	erplace ait!	1	Date / 23	/07	Ro	ssv	ille		
Bal	permit Depar Impor any Ir		21. Signature of Furferal Service Light	unely h.			ell	y Fun	era	l Hom	ie o			Approximate	
8760, 5	Physician /Medical Examiner and the prival-transit	dical Examiner	23a. Part1. Enter the dilease of companion, or heart failure. The only of shock, or heart failure the only of shock or condition resulting in death)  Sequentially list conditions, if any, leading to immediate failure for the conditions of the con	b. Due to (or as a consect of the co	quence of):  nia quence of):  11 Lun									Interval Betweer Onset and Deat	1
Box 6	Attending Physician: The law requires that the death certifica cleath. cctor. After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3[	∃Ectopic preg ∃Other <i>(sp</i> ed					2	23d. Date Mor	e of deliventh	ery Day Year	
rds, P.	w requires that: been signed by should be deta	þ	Part II. Other significant conditions o	ontributing to death but not res	sulting in the u	nderlying cau	ise given	in Part I.		23e. Did to				he cause of death	
Division or Vital Records, P.O.	: The law recate has bee page 2 short	Completed							-	24a. Was autop perfo 1∐ Yes		p	Vere auto prior to co leath? □ Yes	opsy findings avail mpletion of cause 2□ No	able of
r Vita	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Pinpatient 2	] ER/Outpatier	nt 3□ DOA	Othor	26. Place of □					er (Specil	5v)	
sion o	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Tirector: After this certificate ha completely filled in by the funeral director, page	ation: T	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be		28b. Time o Injury	М				I. Describe I					
Divis	oltal or Att urs efter de ral olrect lled in by t	Certification:	4 Homicide determined	building, etc. (Speci	ify)					City or Tov	vn, State,	)		al Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Tir completely filled in I	Medical	29a. Certifier 1 ▼ Certifying Ph (Check only one) 2 ■ Medical Exam	ysician: To the best of my kniner: On the basis of examin and manner stated.	owledge, deat ation and/or in	n occurred at vestigation, i	the time	e, date and plant nion, death o	ace, and ccurred	at the time,	cause(s) date and	and ma I place, a	nner as s and due t	stated. o the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier  30. Name and address of person who	completed cause of death (Ite	m 22a) (Typo	B		00000			7/	19/	120	Day, Year)	
	Sta Registr		Dr. Pierre Valeus 31. Date filed (Month, Day, Year)		Klins	quare	Dri	ve, Ba	ltic	nore 1	MD .	212	317		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23633 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2007 **Physician** 20 9:45 P.M Alan H. Hoffman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium

If Under 1 Year | If Under 24 Hrs. Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Balt Maryland 8. Date of Birth (Month, Day, Year) **Funeral** Months XXM 2□ F Hours 60 216-52-3662 Director 2/27/1947 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 ☐ Yes 201No Owings Mills Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 152 Spectator Lane 21117 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines ones. 1 ☐ Yes ANO If Yes, Give Year or Dates: 1 ☐ Never Married 🏋 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify. White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobiles Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Hoffman Ann Weiss ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Hoffman/ daughter 60 East 3rd St. Apt. 13 New York, New York 10003 20b. Place of Disposition (Name of cemetery, orematory or other place)
EVANS FUNCTAL
Chapel- Bel Air 20a. Method of Disposition July 24, 2007 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 0 23a. Pa.1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shinck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a PANCREATIC CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 ▼ No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hol To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TAKIY 131. Date filed (Month, Day, Year) 2300 DULANEY VALLEY RD. TARIQ MAHMOOD TIMONIUM, MD 21093 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

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	State of Maryland / Department  1 - State Registrar  Certificate	of Health and Mental Hy	•
* 10 V 10 V	Decedent's Name (First, Middle, Last)	2. Date of De	ath 3. Time of Death
Physician /Medical	MELVILLE CARL HANEY	July	20 JODA 2:00PM
Examiner		own, or Location of Death	4c. County of Death
	GOOD SAMARITAN HOSPITAN B.	AZTIMORCO	N/A
- Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1  1 ☒ M 2 ☐ F Yrs Months	Year If Under 24 Hrs. 8. Date of Bir Days Hours Min. (Month, Da 9/5/19	th 9. Birthplace (State or Foreign Country)
Director	251–46–1478	9/5/19	NORTH CAROLINA
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, its Madical Exaction must be notified at once.  To Re Completed by Funeral Director	MD BALTIMORE PARKVILLI	<u> </u>	1 ☐ Yes 2 X No
or 2	10e. Street and Number 10f. Zip C	ode	10g. Citizen of What Country?
ath wath was 23a	65 ODEON COURT	21234	USA
6 Atter death v or iteme 23s other mast	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. If Yes, specific	nt of Hispanic Origin? (Specify Yes or No y Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
) )036 nours att iral; or iral; or	3 🖾 Widowed 4 🔲 Divorced Year or Dates:	Xio Specify:	Specify: WHITE
21215-00 ed within 72 hou ygiene. ner than 'nature it, it a Medical E. Completed	15. Decedent's Education 16a. Decedent's Usuaf (Specify only highest grade completed) (Give kind of work	Occupation done during most of working retired)	16b. Kind of Business/Industry
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HAM CL 1d 21215-1 itled within 72 h Hygiene other than 'natu	12TH GRADE PRESSIVAI  17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	
Viand	CARL HANEY	HATTIE UNAVAI	· · · · · · · · · · · · · · · · · · ·
Melville Hanees  nore, Maryland 21215-0036  ages 1 and 2 should be filed within 72 hours att int of Heelth and Mental Hygiene.  ttiff them 27 is marked other than "natural; or y or other traumatic event, tra Madical Exertil To Be Completed by F		Street and Number or Rural Route Number COURT PARKVILLE, M	
Te	20a. Method of Disposition 20b. Place of Disposition (Name	•	20c. Location - City or Town, State
ages ant of your	1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  METRO CREMATO		CATONSVILLE, MD
Me i Baltimore, permit. Pages 1 ar Department of Hee Important: if tent's any injury or other once.	21. Signature of Funeral Service Licensee , 22. Name and	Address of Facility THE JOHNS	ON FUNERAL HOME, P.A. WSON, MD 21286
	23a. Fart1. Enler the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.		rrest, Approximate
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Severe condition  Due to (or as a consequence of):	OBSTRUCTIVE A	Onsel and Death  OSCOTO
d d	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of):		
Box 68760, eath certificate be executed attending physicien and for use as the burial-transit clan/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of);		
Records, P.O. Box 68 The law requires that the death certifical site has been signed by the attending phyage 2 should be detached for use as the completed by Physician/Medicompleted by Physician P	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of dealh 5 ☐ Other (spec		23d. Date of delivery Month Day Year
P.(	Part II. Other significant conditions contributing to death but not resulting in the underlying car	ise given in Part I 23e Did t	obacco use contribute to the cause of death?
rds, quires th	CORDNARY ARZERT DISEME		Yes 2 □ No 3 □ Probably 4 □Unknown
al Record  The law requir cete has been si page 2 should		24a. Was	
Re la age 2			ormed? death?
Vital Rec stcian: The law rectificate has be irrector, page 2 s	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only of	2☑No 1☐Yes 2☐No
of Vi hysicia his cer al direct	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Hopatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other	
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Division of Vital Records, tal or Attanding Physician: The law requires to selter death.  at Director: After this certificate has been signed in by the funeral director, page 2 should be Certification: To Be Completed by	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specity)	office 28f. Location (- City or Tot	Street and Number or Rural Route Number, wn, State)
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and due to the n my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the		License number	29d. Date signed (Month, Day, Year)
	No MODICAL ATTONOM	DOD62239	July 23 2007
11/2	30. Name and address of n who completed cause of death (Item 23a) (Type, Print)	YAW NOO. M	0
) 0	600D 16W41170	MOSP 1702 BA	17 med
State Registrar	31. Date filed (Month, Pay, Year) 32. Redistrar's Signature		

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Iaderosa Joseph 11:00 AM July 19 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 6909 Holabird Avenue Dundalk Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days **f**∑M 2□ F 77 March 18,1930 140-22-4115 N.J. Usual Residence of Deceden 10c. City, Town or Location 10b. County 10d. Inside City Limits Md. Baltimore Dundalk 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6909 Holabird Ave. 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married 2 No 1 ☐ Yes 2X No White Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Shipping 12 yrs. yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfonso Iaderosa DeToro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 6909 Holabird Ave, Baltimore, Md. Jean Iaderosa 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State July 20 Bayview Crematory Baltimore 4 □ Donation 5 Other (Specify) 2007 Signature Funeral Service Lic Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. P.11. Enter the disease, or complications that caused the shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify)

**Physician** /Medical Examiner

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page 2

funeral After or Attending death. the 1 after death filled in by

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Important: if any injury o

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

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.. Pages 1 and 2 should be filed witnent of Health and Mental Hygier tant: If Item 27 Is marked other thilury or other traumatic event, the

Director

Funeral

Completed by

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

9 Unknown

IF FEMALE: 23b. Was decedent pregnant

2007

4□Pregnant at time of death 9□Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

perform

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

examiner?	medical			26. Place of Dea	th (Check only ope)
	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 [	OOA Other: 4 Nursing H	ome 5 Residence 6 □Other (Specify)
27. Mann of Dea 1 Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3□ Suicide 4□Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier	1 Certifying Ph	ysician: To the best of my kn	owledge, death occurre	ed at the time, date and place	, and due to the cause(s) and manner as stated.

taminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year)

Mmeland address of pers completed cause of death (Item 23a) (Type, Print ab

State Registrar

Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) mirie Month 3:36 PM **Physician** 07 20 Holmes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Feb. 18 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Year Months Hours 60 1 M 2 □ F Feb. 1947 213-50-1610 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 🖺 No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 20850 United States 12705 Circle Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 ZNo filed within 72 hours after ☐Yes 2 Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) Auto Parts Business College (1-4or 5+) 5+ Elementary/Secondary (0-12) marked other than 0wner 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be d 2 should be fi h and Mental h Valerie Liggett George W. Imirie, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a ant: If item 27 is jury or other trai 11377 Hayman Drive, Princess Anne, MD 21853 Allan F. Imirie/Brother Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 26, Rockville, Maryland 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or Rockville Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 21. Signature of Funeral Service Licensee M01346 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiogenic Shock Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Arrhythmia/Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence of): Examine The law requires that the death certificate be executed Myocardial Infarction physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Respiratory Failure/Arrest Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has b irector, page 2 s autopsy performed? /es 22 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐ Yes 2 📆 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065478 ance 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad Sanaei, M.D. 9901 Medical Center Dr., Rockville, MD 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 4 Registrar

			1 - For State of Ma	•	artment of Heartificate of De		ntal Hygien Reg. N	6U31	23637
	Physici	an	1. Decedent's Name (First, Middle, Last)		TOHAK	SON 2	Date of Death Month	ay Year	3. Time of Death
•	/Medic Examin		4a. Facility Name (If not institution give street and number) of VA Renate & Estended Care	Biltimore	4b. City, Town, or Low Baltin	cation of Death		Lc. County of Death	'A
(0 t)	Funeral Director		251-26-0275 10M 20F	(In yrs. last birthday)		Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea UNE 1919	9. Birthp County	lace (State or Foreign try) THE CAROLINA
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23s or 28s-1 ehow event, I'ra Madical Examinat must be notilized at	Director	Usual Residence of Decedent  10a. State  10b. County  MARILAND  10e. Street and Number	10c. City, Town or Lo	BALT I	MORE	C17	Itizen of What Coun	0d. Inside City Limits 1    1    Yes 2 □ No  try?
036	be filed within 72 hours after death with the Maryla tal Hygiene. Id other than "natural", or items 23s or 28s1 ehoi event, I'ra Madical Examinat must be notilited at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 X Yes 2 N H Yes, Give Year or Dates:	0	Was Decedent of Hispa if Yes, specify Cuban, N	anic Origin? (Specif Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: BL	etc.
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Baltimore, Mar	of Health of Hem 27 I		19a. Informant's Name/Relationship (Type, Print)  MARK C. JOHNSON (So  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	20b. Place of Dispo	natory or other place)	ORD RD.	BALTI		21218
Baltir	permit. Pag Department Important: I eny injury c		21. Signature of Funeral Service Licensee		REMATOR Name Ind Address of		WNJR	ALTO MIL	L HOME
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)	oke	er the mode of dying, s	such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
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8760, EM	cate be executed by sicien and the burial-transit	dicai Examiner	that initiated events c.	a consequence of):					
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rds, P	w requires that the der been signed by the a should be detached to		Part II. Dther significant conditions contributing to death but Peripheral Vascular	t not resulting in the un	nderlying cause given in	n Part I.	23e. Did tobacci	o use contribute to the	
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Division of Vital Records,	> 0 0	To Be	25. Was case referred to medical examiner?  1  Yes 2 No		ot 3 DOA Other:  28c. Injury at Work?			6 □Other (Specifi	v)
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	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of and manner sta	examination and/or in	vestigation, in my opinio	on, death occurred	at the time, date a	ind place, and due to	the cause(s)
	5 W 5 20	-	29b. Signature and title of certifier  MD	outh (Non-201)	29c. License nu D 56 Print) ×1AN Balton			Date signed (Month,	23, 2007
	211		30. Name and/address of person who completed cause of de 3 9 0	Bud Type,	Balton	orl,	mp.	21218	) 
	Sta Registr		1111 2 4 2007	S. Asi	sele!				

	State of Ma		artment of Health and N	_	_	7 00000
	1 - State Registrar	•	tificate of Death		eg. No.	1 43530
Blustician	Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Y	3. Time of Death
Physician /Medical	Beatrice R.		Johnston	07	18 0	7 2:27 Am
Examiner	4a. Facility Name (If not institution, give street and number)	4:31	4b. City, Town, or Location of Death		4c. County of	IMORE GIV
		SPITAL (In yrs. last birthday)	BALTIMORE If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
Funeral Director	246-24-5846 1□M ¾□F	83 Yrs.	Months Days Hours Min.	(Month, Day 08 28		NC NC
9	Usual Residence of Decedent	10c. City, Town or Lo				10d. Inside City Limits
Ch show	10a. State 10b. County					1 ∑ Yes 2 □ No
SEATRREE  336  Jis after death with the Maryland Jis or Hems 23a or 28e-f show confiner must be recitified at by Funeral Director	MD NA 10e, Street and Number	Balti	10f. Zip Code		0g. Citizen of Wh	at Country?
T P P P P P P P P P P P P P P P P P P P	3818 Greenspring Ave		21211		U.S	- A -
death death	11. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-		American Indian, White, etc.
S6 after after or the y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ N	lo	1 ☐ Yes 2X No Specify:	, , , , , , , , , ,	Specify:	Black
5-0036 72 hours atter neturel; or the disal Esamina	3 ¼ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education	16a Dece	dent's Usual Occupation		16b. Kind of Busin	
15- n 72 n 72	(Specify only highest grade completed)	(Give	kind of work done during most of work DO NOT use retired)	king	Miso Co	·
TON 21215-00 a filed within 72 hour typigne. other then "neture went, the Medical Event,	Elementary/Secondary (0-12) 12th grade College (1-4or 5-	Com	puter Operator		Fort Me	eade, Md
Ind 212  Ind 212  be filed within that Hygiene.  event, then  Be Comp	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
aryland should be file and Mental Hy s marked oth summatic event	Eugene Redden		Pansy	Wilson		T. O. (1)
	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru			
office, M	Harry C. Johnston-Grand 20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Ave Ba	20c. Location - Ci	ty or Town, State
)— Q 8.2 = 5	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) on Forest Vet 7	/24/200	7 Owing	gs Mills, Md
altim mit. Pa partmen portent: injury	21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility			
Bal permi Depa Impo eny in	Xale March	_ 4	arch F/H West 300 Wabash Ave	, Balti	more,	Md 21215
	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one sause on each lin	the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	LATED CO				Onset and Death
/Medical Examiner		a consequence of):	C1 (H) - C0		.0411	
	Sequentially list conditions,	11C BOW a consequence of):	EL with sef	7116 51	HOCK	
executed executed ial-transit	cause. Enter Underlying Cause (Disease or injury		US COLITIS SEC	endary	to e.di	17
760, 760, or be executed sician and burial-transit	that initiated events	a consequence of):	00,110	J		00
76( le be rsicia e bur	a DIC					
of Vital Records, P.O. Box 683 Physicien: The law requires that the death certificate this certificate has been signed by the attending phyral director, page 2 should be detached for use as the TO Be Completed by Physician/Medic	IF FEMALE:			~	1	
BEATRICE  al Records, P.O. Box 68  The law requires that the death certifica ale has been signed by the attending ph page 2 should be detached for use as the	23b. Was decedent pregnant in the past 12 modits?	2 Fetal death 3	Ectopic pregnancy		23d. Date	
O. I. O. I the de the de ched f	1 Yes 2 No 4 Pregnant at 9 Unknown	time of death 5	Other (specify)			
A)C., P.O. that the did by the detached	Part II. Other significant conditions contributing to death but	ut not resulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
Cords, wrequires t been signe should be o	Hypertension Diabe	fer Melli	his Type 11,	1 □ Y	es 2□No 3	Probably 4 Unknown
Records, he law requires t s has been signe ge 2 should be o	COPD Abdominal acr	hie anei	Sellen.	24a. Was a	an 24b. We	re autopsy findings available of to completion of cause of
The it age 20 Page 20	lower exprenity DVT.			perfor	med} dea	ath? Yes 2 No
Vital F Vital F icien: Th certificate rector, pag	25. Was case referred to medical			th (Check only or	76)	
of V Physic this of	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie				ence 6 Other	
On Congress After After funeration;	27. Manner of Death  1 Natural 5 Pending (Month, Day)	Year) 28b. Time o	f 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe n	ow injury occurred	
OHNSTC Division of Division of Division of Mission of Mission of Mission of Division of Di	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	ury - At home, farm, str				or Rural Route Number,
Div din b	4 Homicide determined building, etc	c. (Specify)		City or Tow	n, State)	
DIVI  DIVI  PHOSPITED OF A  PLAN FOUND STREET  PERMITTED DIVE  PERMITTED TO THE  PER	29a. Certifier Check only 2 Medical Examiner: On the basis of	of my knowledge, deat	h occurred at the time, date and place	, and due to the o	cause(s) and manr	er as stated.
문문문 등 📆	one) and manner sta	ited.	29c. License number			Month, Day, Year)
To To CONT	29b. Signature and title of certifier	4.5	RES 000		7/10/	17
	30. Name and address of person who completed cause of de	eath (Item 23a) (Tunn			1110]	UI .
5	Deep Sharma PGJ-2, Goo		citan Hospital.	Baltin	Ore . 1	AD.
State		ar's Signature				
Registrar	111 2 / 2007 /	50 May	DAR. B			

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10:35 AM JULY 21 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 ☐ M 2 🖫 F Yrs Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director More 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number or be permit. Pages 1 and 2 should be filed within 72 hours after death wind Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b X do Funeral ) ()Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** 5 DAYS /Medical Due to (or as a consequence of): **Examiner** UROSEPSIS 5 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) Be Completed by

Vital Records, P.O. Box 68760, ERNESTINE Division or

After this certificate has been si funeral director, page 2 should I

Certification: To

Medical

State Registrar 29a. Certifier

24 hours after death. e Funeral Director: After filled in by

completely within 2

	1∐Yes 2 X 9 ☐ Unknown	No		Unknown				.,,						
Par	t II. Other signific	ant conditions	ontributin	g to death but not re	sulting in the und	erlying	caus	se given in Par	rt I.	2	3e. Did tobacco us	e contribute to	the cause of death	?
_	MUL	TIPLE	SCL	EROSIS							1 ☐ Yes 2 ☐	No 3□Pro	bably 4 Unkno	own
-											4a. Was an autopsy performed? □ Yes 2 No	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings availa ompletion of cause 2 ☐ No	able of
25.	Was case referre	d to medical						26. Pla	ace of Deat	th <i>(Ch</i> e	ck only one)			
	examiner? 1 ☐ Yes 2 X N	lo	Hospital	1 Inpatient 2	ER/Outpatient	3 🗆 🛭	OOA	Other: 4 🗆 I	Nursing Ho	ome 5	5 ☐ Residence 6	□Other (Spec	ify)	
27.	Manner of Death 1 Natural 2 Accident	5 Pending investigation	n	Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c.	Injury at Work? 1 ☐ Yes 2[		28d. D	Describe how injury	occurred		
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		Place of injury - At building, etc. (Spec		et, facto	ory, o	ffice			ocation (Street and lity or Town, State)	Number or Ru	ral Route Number,	

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

JULY, 21, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore Caton

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State o	f Maryla	nd / Depa	artmen rtificate				lental H	Hygie Reg	6. 0	17	230	541
			Decedent's Name (First, Middle, La	ist)							2. Date of	Death	Day	Voca	3. Time of	Death
	Physici		Albert Kilberg								Month June	25.	2007	Year	10:35	A <sup>M</sup>
1	/Medic Examin		4a. Facility Name (If not institution, give	e street and nur	n <i>ber)</i>		4b. City,	Town, or	Location of	of Death			4c. County	of Death	-	
			111 Hamlet Hill	Road #4	104		Bá	alti	nore							
	Funeral		5. Social Security Number 6. S	Sex		. last birthday)	If Under		If Under		8. Date of	Birth Day, Y	oarl	9. Birth	place (State o	or Foreign
	Director		213-05-5605	1 M 2 □ F	92	Yrs.	Months	Days	Hours	Min.	June	20,	1915		land	
	P _		Usual Residence of Decedent													
	arylar show	_	10a. State 10b. County		10c. C	ity, Town or Lo									10d. Inside C	•
	Be-f	cto	MD			Balti									1 X Yes	2 140
	it ti	E e	10e. Street and Number	D 1 //			10f. Zip		1.0			10g	. Citizen of W	Vhat Cou	intry?	
	ath v	by Funeral Director	111 Hamlet Hill					212					USA			
	er de	nu	11. Marital Status	Armed Fo	edent Ever in t irces?	J.S.   13.	Was Deced If Yes, spec	lent of Hi of Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or Rican, etc.)	No-		e - Amer k, White	ican Indian, , etc.	
36	's aft	Ϋ́F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 Yes If Yes, Gn Year or D	/A	тт	1 ☐ Yes	2 <b>X</b> No	Specify:				Specify	wh:	ite	
21215-0036	72 hours after death with the Maryland naturel', or items 23a or 28e-f ehow iteal Exarul or must be rediffed at		15. Decedent's E	1	ates. WW	1	dent's Usua	I Occupa	ation			16	b. Kind of Bu	siness/l	ndustry	
15	in 72 in ma	Completed	(Specify only highest gr	ade completed)		(Give	kind of wor DO NOT us	rk done d	during mos	t of worki	ng	10	D. 14114 Of Du	31110334	ild ustry	
12	with iene.	E	Elementary/Secondary (0-12)	College (1	I-4or 5+)	manuf	actur	ing	execu	ıtive	2		clot	hing	r	
b	Hyg othe	Bec	17. Father's Name (First, Middle, Last	")								idle, Ma	iden Sumam			
Maryland	12 should be filed within in and Mental Hygiene. 7 ie marked other then "reaumatic event, the Med	To B	Hershel Kilberg						Ka	ather	ine E	ola:	nsky			
ary	shound N	-	19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	or Or Rura	l Route Nu	m <i>ber, C</i>	ity or Town,	State, Z	p Code)	
	nd 2 alth a 27 is		Richard Kilberg/s	son		215 V	7. 90t	h St	reet	#9C	New ?	York	, NY 1	.0024	4	
ē,	s 1 a f Hea item othe		20a. Method of Disposition	_		Place of Dispo	sition (Nan	ne of ther plac	a)	C	ate	20	c. Location -	City or 1	own, State	
Ë	Page nent c nt: if ry or		1 Burial 2 Cremation 3 4 X Donation 5 Tother (Speci		State	333(3.)y, 3.3	matory or o	inor prao	1							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: if Item 27 ie marked other then "naturel", or Items 23a or 28e-1 ehow any injury or other traumatic event, the Medical Exactiner must be redified at once.		21. Sign tore of Funeral Service Lice		irecto	r St	2 матре ад	d Addres	s of Facilit	Yard	655 W	I. B	altimo	re S	Street	
Ö	Dep Imp		Jann /	Mal	0		Itimo			21201			a		,	
			23a. Part   Enter the disease, or com shock or heart failure. List only	plications that o	aused the dea					cardiac c	r respirator	y arrest			Approximat	6
	Physician		Immediate Gause (Final	One cause on e	a h l	,				0	0 -				Onset and	
	/Medical		disease or condition resulting in death)	a. Due to	or as a conse	quence of):	Love	var	7-2	للس	213				day	
	Examiner		Mariner County County County County	P	9	0 1-	- R.=	T.O.							7	dt
		Je.	Sequentially list conditions, if any, leading to immediate	Due to	or as a c	uence of):	~~								1 /40000	Civi
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0 9 20	Man	LAN	diam	reli	1	e- W	No.	مط	97	w427		1000
o,	an ar	EX	resulting in death) Last	Due to	s a conse	quence of):			M. Section		F. 1. 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	400	.,	-	0	
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	dicai		_ d												
9	rtifica ng ph as th	Med	IC COMM C													
Вох	leath certifica attending ph s for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregr		Ectopic pr	ennancy					23d. Date			
	deal	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of		Other (sp						Mor	nth	Day	Year
P.O.	at the by the	چُ	9 Unknown													
	w requires that the death been signed by the atte should be detached for	5	Part II. Other significant conditions	contributing to de	eath but not re	sulting in the u	nderlying c	ause give	en in Part I.		23e. D	id tobac	cco use contr	ibute to	the cause of o	leath?
ğ	equir en si ould	D D									1	☐Yes	2 10 No	3 🗌 Pro	bably 4 🗆	Jnknown
of Vital Records,	law ras be	Completed by									24a. V	Vas an utopsy			opsy findings ompletion of a	
æ	The ate h	E O									p 1□ Ye	erforme	d?   d	leath?	2□ No	2000 0.
ita	hysicien: The law his certificate has I I director, page 2 s	Be	25. Was case referred to medical						26. Place	of Death	(Check or					
<b>&gt;</b>	Physicien: this certific ral director,	2	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 🔲 I	npatient 2	ER/Outpatier	nt 3 DO	Othe	er: 4 □ Nu	ırsing Ho	me 5 R	esidend	e 6 □Othe	er (Spec	ify)	
0	ng Pl		27. Manner of Death 1   Natural 5  Pending	28a. Date (Mon:	of Injury th, Day Year)	28b. Time o	f 2	8c. Injury Work	at		28d. Descri	be how	injury occurr	ed		
Ö	Attending r death. ector: After by the fune	atic	2 Accident investigation				М		Yes 2□	No						
Division	irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At I	nome, farm, str	reet, factory	, office			28f. Locatio City or	n (Stree Town, S	et and Numbe State)	er or Ru	ral Route Num	ber.
	itel or rai D led ir			inii.												
	To the Hospitel or Attending Phwitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medicai	29a. Certifier 1. Certifying Pl (Check only 2. Medical Exa	hysician: To the miner: On the bi	best of my kn	owledge, deat	h occurred vestigation.	at the tim	ne, date an	d place, a	and due to	the caus	se(s) and ma	nner as	stated. to the cause(s	;)
	the h the f	Aed	one)	and man	ner stated.											
	or or no	<	29b. Signature and title of certifier				290	LICENSE	number			29d	. Date signed	(Month	, Day, Year)	
			Philip V	ive,	3.17.			000	11	215		17	-16	-0	7	
			30. Name and address of sesson who	completed caus	e of death (Ite	m 23a) (Type,	Print)								2,212	
			PHILL ZIEVE	JOHN	egistrar's Sign	KINS	BA	TVI	En	3É	1160	77	CEA	TEI	2,212	.24
	Sta Registr		31. Date filed (Month, Day, Year)	2007	bedake a	K A	BAR!									
				100	THE PARTY OF	- AU	AND AND AND									

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 30 M **Physician** 2007 enreuthe mma /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Talbot 05101 lemori' Hospital al Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-28-19/ 9. Birthplace (State or Foreign Country) If Under 1 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ■ M 2 💢 F 92 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or edical Examiner must be SA 21206 Sheldon < 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after a ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Iten ury or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ome maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Easton Mary M. Peach - daughter 20a. Method of Disposition 12 Downing Street Maryland 21685 Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 7-18-2007 Baltimore, Maryland 22 Name and Address of Facility Evan's Fineral Chapel & Cremation Services - Parkville Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Consequence 8800 Harford Road Parkville Maryland 21234 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hillind. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea shock, or heart failure toral wall Myriardia Immediate Cause (Final **Physician** hows disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation Year) 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

To the Hospital or Attending Physician: neral Director: A within 24 hours a

en

29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Y. CHRISTADOSS RAJAS; NC; H, 522 I DLE WILD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

AVE

	7	= State Registrar						Cei	runcai	te ot L	Death			Reg	J. No	1	L C U
	_	1. Decedent's Name (Firs	st, Middle	, Last)				-					2. Date		Davi	Vaar	3. Time of D
sician edical		Marlene L	eBouy	vier									Month July		Day 2007	Year	6:25 A
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Division or Vital Records, P.O. Box 68760,

within 24 hours a completely

filled in by

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTON

JUL

6 ☐ Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



6

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

( pp

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 19b, perFH, g869, 7/24/07 TT Certificate of Death Reg. No, 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2007 4:12p July 18 Evelyn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 86 214-14-9470 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes ¾☐ No Director Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code U.S.A. 21230 "natural", or items 23a 2518 Hollins Ferry Road 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black 3 Widowed 4 □ Divorced mit. Pages 1 and 2 should be filed within 72 ho nartment of Health and Mental Hygiene. octant: If item 27 is marked other than "naturinjury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Agnes Hospital 12th grade 2yrs Nurse Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Veneta Parker Bernard Hemsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

323. Zepplin Ave. Brooklyn, MD 21225

WHO 21108 19a. Informant's Name/Relationship (Type. Print) Bernard Johnson-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/24/07 Crownsville, Md Crownsville 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licens 4300 Wabash Ave, Baltimore, 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERY **Physician** CORUNARY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, francisco. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. \$ 1 Yes 2 No 3 Probably 4 Onknown Completed cate has been a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident fter death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital

10 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUL 2 4 2007

UMA

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D 50 59107

29d. Date signed (Month, Day, Year)

REISTERS TOWN

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** М July 2007 Robert Carroll LeBrun 17, 03:01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1**⊠** M 2□ F Director 65 Oct. 18, 1941 Maryland 212-40-4727 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 XNo Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1007 Seamount Road 21015 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Carroll LeBrun Mary Violet Martel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Toni LeBrun / Wife 1007 Seamount Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 7-19-07 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Broncho Plaural 10 0945 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: EDICINA KOOCIT MSCOA 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Year this certificate has been signed by the atte al director, page 2 should be detached for in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural al or Attendir after death. I Director; Al 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 Homicide within 24 hours af To the Funeral D completely filled i 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

31. Date filed (Month, Day,

Marco

30. Name and address of person

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

Zamora, mD 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Registrar

500

29c. License number

29d. Date signed (Month, Day, Year)

hesapeake Drive, Bel Air 21014

Registrar

State Registrar 4940 EASTERN AVENUE BALTIMORE, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

			For	State of Mar				nd Mental	Hygien	e 2 1 1 1 7	00010
			1 - State Registrar	<u> </u>	Ce	ertificate of	Death		Reg. No	6. UU1	23043
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	/Medic		Margaret 1	Michno				Jul	y 19	2007	0735 AM
	Examin	er	4a. Facility Name (If not institution, give		1. 1.	4b. City, Town, o	r Location of	Death	40	c. County of Death	1
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	yland		10a. State 10b. County	1	0c. City, Town or I	_ocation					10d. Inside City Limits
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	er de	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Yes Puerto Rican, et	or No- c.)	<ol> <li>Race - Amer Black, White</li> </ol>	
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Maryland 21215-0036	2 should and Men is marke		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mai	ling Address (Street	and Number	r or Rural Route I	Number, City	or Town, State, Zi	ip Code)
Σ	1 and 2 Health tem 27 i		Sandralee R. Petri	l (Daughter	) 100;	37 Icabod	Lane,	Middle	River	Md. 212	220
ore	of He		20a. Method of Disposition 1   1   Description Disposition Dispos		20b. Place of Disp cemetery, cr	oosition (Name of ematory or other place	сө)	Date	20c. L	ocation - City or T	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examination to other traumatic event.		4 □ Donation 5 □ Other (Specify,			Cemetery	07	7/23/200	7 Ba1	timore,M	aryland
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sio	tendi leath tor: A the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ N				
Division of Vital	or Attending Physician: The law requires that the death certifica siter death. Director: Aftar this cartificate hes been signed by the eltending ph in by the funeral director, page 2 should be detached for use as the	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, s (Specify)	treet, lactory, office			tion (Street a or Town, Stat	ind Number or Rui te)	ral Route Number,
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			30. Name and address of person who c	ompleted cause of deat			-000			911,2	-00 1
	12		Sarah Miller	ND 49		eva Ave	Roll	6 harr	MA	21224	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mckenith 6:20 PM 2007 James /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UMMC Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Days Hours Director North Carolina 245-50-5299 02/12/1936 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show s itca Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21201 124 West Franklin Street Apt. 207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? No Yes 2 □ No (UNK) IFYes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced er than "natur, Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law enforcement Police event, the 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ပ Ora Smith traumatic Webster Wesley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and.
Department of Health
Important: If Item 27
any injury or other tr 404 Hide Away Loop Apt. L. Glen Burnie, Maryland Mildred B. Watts / Daughter
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/24/2007 | Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral /Medical Due to (or as a consequence of): Examiner parench Intra coordinate flet con 100 me if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit hypertensive P.O. Box 68760 Physician/Medical as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page Division or Vital 1□ Yes 219No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mannes of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fo the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mithell a Hutle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Gutshall

31. Date filed (Month, Day, Year)

JUL 2 4 2007

3 Registrar's Signature

Greene St, Bathmere MD

1 - For State Registrar

Dhue	iaian	1. Decedent's Name (First,	<i>Vliddle, Last)</i>							Month	eath Day	Yea		. Time of D	eath
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Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director,			rtifvina Physici	an: To the bes	t of my knowle	edge, death	occurred at the	time date	and place, a	and due to the	e cause(s) :	and manner	as state	d.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 1.05 JULY PM Robert James Miller, Jr. 18 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CECIL CECIL COUNTY ELKTON HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Hours May 29, 1942 Pennsylvania 1 M 2 □ F 65 Director 219-42-1205 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director Elkton Cecil Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 USA "natural", or items 23a Unknown Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ voiced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation injury or other traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene.

m 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Auto Repair Auto Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luella Jean Lingenfelter Robert James Miller, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Mahogany Run, Pittsford, New York, 14534 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trains Tina Olson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 07-20-07 Towson, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): **Examiner** KENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Natura 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) A 0063 486 JULY, 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.A. HAMADEH ELKTON, MD BOW 106 STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of He State Registrar  State of Maryland / Department of He Certificate of L			ene.	23653
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	Funeral Director		5. Social Security Number 6. Sex 12-M 2 F 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min.	Feb, 21,	1921 Sout	rtipy) a la
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Division of Vital Records. P.O.	or All after of Direction by	Certification:	4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or Town	reet and Number or Run n, State)	ar mode indiriber,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 20, 2007 2:20P Ju1y Harold J. Nicholson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perry Hall Baltimore 9535 Bauer Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Aboutho Davis Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Director Dec. 18, 1915 Maryland 217-05-6443 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Perry Hall Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be 1 U. S. A. 9535 Bauer Avenue 21236 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3altimore, Maryland 21215-0036 Specify: þ 3 MWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heavy Equipment Elementary/Secondary (0-12) College (1-4or 5+) Diesel Mechanic 8 Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Ellen Welsh 2 Samuel Nicholson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Nicholson (Son) 8 Wagner Way, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gdns. 07/25/2007 | Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee Buena well 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute Msocondial **Physician** /Medical Due to (or as a consequence of): Examiner COYONary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence 4) Examiner physician and the burial-transit Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify). n signed by the a P.0. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been signed 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred I or Attending Patter death. Certification: 5 Pending Injury 1 Natural investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a within 24 hours a 1 🔀 CertifyIng Physicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ) MURES CO 00017679 7/23/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGATON H. ESCAL ANTO M.O. 32 Registrar's Signature JUL 2 4 31. Date filed (Month, Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death - <sup>Day</sup> 2007 July 21, George E. Olias 8:35 Ам 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Oak Crest Care Center Parkville If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 6, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Days Hours **1**X ∩ M 2 □ F Maryland 94 215-05-6797 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore Parkville 1 ☐ Yes 2 XNo MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21234 8800 Walther Blvd.Apt.3505 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Director 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Esskay Quality Elementary/Secondary (0-12) College (1-4or 5+) 12 Meats 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie E. Richter George F.Olias 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21234 8800 Walther Blvd.Apt.3505-Parkville,MD Emma N. Olias-spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Parkwood Cemetery 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State July 25,2007 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 8800 Harford Road Parkville,MD 21234 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke disease or condition resulting in death) Due to (or as a consequence of): beilla tion 201 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1)5864

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

23 200 ~

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

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**Funeral** 

Director

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Baltimore, Maryland

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Examiner Physician/Medical þ Completed Be Certification: To after death.

Director: /

1 Naturai

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

Yours within 24 hours and To the Funeral Directory 08

Hospital or Attending

State

Registrar

Medical

DHMH 17 Rev 1/2001

(Month, Day Year)

and manner stated.

2007 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Monia

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3800

			For State Registrar		State of Ma	rylanc		partment of F ertificate of			giene Reg. No.		23656
	Dhamini		1. Decedent's Name	(First, Middle, Las	st)					2. Date of De Month	Day	Year	3. Time of Death
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ore,	Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  In marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation 3	Removal from State	St.ce	metery c Joh:	position (Name of rematory or other plac n Catholic	July			ation - City or	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 19b per fh e869 7-25-07 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For Amend #2, perMD, g869, 7/24/07 RegistrarAmen #5, perFH, g869, 7/27/07 Certificate of Death Reg. No. 2007<sub>007</sub> 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July **Physician PERKINS** 2:35A M MARGARET ELAINE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 16, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 235-24-2425 79 Yrs West Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2□No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21286 USA Southerly Court #408 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes N No No Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. XXNever Married 2☐ Married 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Systems Analyst Railroad Is marked other 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Hardy Perkins Margaret Elizabeth Brandenburg 19b. Mailing Address (Street and Number or Rural Route Number, Cit**Ohito**n, State, Zip Code) 5218 Sabra Avenue Huber Heights <del>Phio</del> 45424 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any injury or other trau once. Carol Leep PR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Drumation 3 Removal from State Woodmere Cemetery 7/28/07 Huntington, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Septice License 21 6500 York Road Baltimore, Maryland 21212 Mus 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Cancer Physician year /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Tyes 2 DNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has be irector, page 2 s autopsy performed? Yes 2D No 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) NOSP(C 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 🗷 Naturai 5 Pending investigation the Funeral Director: After an Instell filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 58503 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 21 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cluarius IT Towsw MD
AALEW I CHANUES MD 6701 N. Cluarius IT Towsw MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200 PUELISI Month **Physician** 0315 ELEANURA JULI 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW TIMOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Yrs **Director** 212-24-9931 January 01, 1924 **Pennsylvania** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "neturel", or Items 23e or 28e-f shov the Medical Examinar must be confided at 1 ☐Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 1 401 Vogts Lane 21221 United States of America death Funerai Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes No ff Yes, Give Year or Dates: 1 Never Married 2 Married more, Maryland 21215-0036 1 Yes X No Specify þ Specify: White Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any liquy or other treumatic event <u>once.</u> Be George Strauss Beulah Hetrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Joseph Puglisi (Son) 401 Vogts Lane, Essex, Maryland 21221 20c. Location - City or Town, State 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Lake View Memorial PK 07/23/07 Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 1001234 8728 Liberty Road, Randallstown, Maryland 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** more asper /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying e to (or as a consequence of): Examiner physician and the burial-transit speiner o type certificate be executed that initiated events resulting in death) Last Box 68760.0 to (or as a consequence of): Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No jo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. he þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, by The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate ivision of Vital 1 Yes 2 No Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 Tes 2**X** No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After To the Hospitel or Attending Injury 1 KNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide within 24 hours a To the Funerel D 29a. Certifier t 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

Registrar

0

State

31. Date fifed (Month, Day, Year)

BUYVICUL

Baltimore

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrer	State of	Maryland	-	artmen tificate			and M		giene Rag. No.		236	559
	<b>D</b>		Decedent's Name (First, Middle, L.	ast)							2. Date of Dea Month	ith Day	Year	3. Time of	Death
	Physici /Medio		Norma Jean Pri	tt							July	17.	2007	1:25	РМ
1	Examin		4a. Facility Name (If not institution, g.	ive street and numb	er)		4b. City,	Town, or	Location o	f Death		4c. Co	unty of Death		
			2007 Kenny Ct.						wood			1	larford		
	Funeral			Sex 7. 1 ☐ M 21X F	Age (In yrs. last	-	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	Cou	place (State o	
	Director		233-52-7857 Usual Residence of Decedent	10 W 2A31	72	Yrs.					Mar. 26	, 193	5 West	Virgi	nia
	and	-	10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside Cit	tv Limits
	Mary	ō	1 7 7	7		<b>7.</b> 2								1 □ Yes	
	288 100	rec	Maryland Harfo	ora		Eage	10f. Zip	Code				10a. Citizer	of What Cou	ntry?	
	3a or	0	2007 Kenny Ct.					2104	0			USA		,	
	death	Funeral Director	11. Marital Status	12. Was Decede		13. \			-	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ameri	can Indian,	
ထ	of its	Ē	1 Never Married 2 Married	Armed Force		1				, Puerto I	Rican, etc.)		Black, White	etc.	
Ö	rei', o	by	3€ Widowed 4 Divorced	If Yes, Give Year or Date	es:		I□Yes 2	2 XNO	Specify:			Sp	ресify: W	hite	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or itema 23a or 28a-1 ehow ha Madical Examinar musi be notified at	ted	15. Decedent's I (Specify only highest g		1	6a. Deced	dent's Usua	l Occupa	ition Juring most	of works	pa l	16b. Kind	of Business/Ir	dustry	
7	ithin	du	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	OO NOT us	e retired,	)	0. 10.77.	ng				
	ygier ygier t, th	Completed	10				Cler	ical					itomoti	ve	
Maryland	be fill Ital H Id oth	Be	17. Father's Name (First, Middle, Las								(First, Middle,	_	•		
<u>≯</u>	ould Men Marke	2	Clifton Shermar								(nmn)				
Jar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. Insportant: if item 27 is marked other then "naturel; or itema 23a or 28a-1 ehow eny injury or other traumetic event, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship		1						l Route Number				
	l and tealth m 27 her t			aughter	00h Di-				t., E		rood, Ma				
ō	ges it of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from Sta	come	etery, cren	sition (Nam natory or ol	ne or ther place	9)	U	ate	20c. Locat	ion - City or T	own, State	
altimore,	tmen tant:		4 □ Donation 5 □ Other (Spec		Hill	top :	Servi	ce C	orp!	7-	21-07	Tows	on, Ma	ryland	
Ba	Depermit Depermit Import once		21. Signature of Fundral Secrice Clo	ensee		22 I	Name and	as F	s of Facility unera	1 но	me, P.A	١.			
	405 e a	1 A	Juneary my	W			1217 /	701-0	ah	Doo	3 7h-m	~~~	Maryl		
		, .,	23a. Part1. Enter the disease, or conshock, or heart failure. List			Do not ente	er the mode	of dying	, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Bety Inset and D	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Me	tustat.	2(	lur	9	Car	rcer	_			/	on this
	/Medical Examiner		resulting in death)	Due to (or	as a consequen	ce of):	(							-257	
		_	Sequentially list conditions	b											
Т	led sit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0 (0)	as a consequen	ce or):									
	and and	хап	that initiated events resulting in death) Last	c. Due to (or	as a consequen	ce of):					<del></del>				
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687	phys s the	ge		d							.,			8.3	-
Box	eath certific attending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy							224	. Date of deliv	0.04	
ă	atter after	Ciar	in the past 12 months?		n 2 ☐ Fetal death		Ectopic pre					230	Month	-	rear .
0	by the a	sk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknow	n		( )	//							
α,	The law requires thet the ite has been signed by thoage 2 should be detached.	Y P	Part II. Other significant conditions	contributing to deat	h but not resultin	g in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of d	eath?
rds	dires										Letter.	ēs 2 🗆 N	lo 3 Pro	oably 4 🗆 U	Jnknown
<u>ဂ</u>	w require been signature should b	lete									24a. Was a	ın 2	4b. Were auto	nosy findings a	available
Re	he lav e has age 2	Completed					~				autops	sy med?	prior to co death?	mpletion of ca	ause of
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5	Attending Physician: r death. sctor: After this certific by the funeral director.	0	examiner?	Hospital: 1 🗆 Inp.	atient 2 ☐ ER/	Outnation	3 🗆 🗅	Othe	_		ne 5 Reside	-	Other (Spec	5 e l	
ō	eral o	盲	27. Manner of Death	28a. Date of I (Month,		b. Time of		Bc. Injury Work			8d. Describe ho			<i>y</i> )	
0	tending F leath. tor: After the funer	읉	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Day rear)	Injury	м		es 2 □ N	10					
Division of Vital Records,	I or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	200. Place of	Injury - At home etc. (Specify)	, farm, stre	et, factory,	office		2	28f. Location (Si		lumber or Run	al Route Numi	ber,
	s after s after of Dire	Seri	4 El Tombido	Duilding,	өкс. (эрвспу)						City or Town	n, State)			
	To the Hospital of within 24 hours at To the Funerel D completely filled is		29a. Certifier 1 Certifying P	hysicien: To the be	est of my knowled	dge, death	occurred a	t the time	e, date and	place, a	and due to the c	ause(s) and	d manner as s	tated.	
	the H hin 24 the F nplete	Medicai	one)	miner: On the basi and manner	stated.	and/or inv	estigation,	in my op	inion, deatr	n occurre	ed at the time, d	late and pla	ice, and due t	o the cause(s)	,
	To t To t	Σ	29b. Signature and title of certifier	1 -	m		29c.	License	number		, 2	9d. Date s	igned (Month,	Day, Year)	
	T		In				1	15	-48	-11		7/	18/0	1	
			30. Name and address of person who	completed cause of	of death (Item 23		Print)								
7	9 [	į	10/11	- 1-1	1 /1 /	1 ()									1
7			C ASHK	AN	BAH	RI	4N/		2 S.	Atwo	od Rd.,	Bel	Air, M	D 2101	4
7	Sta Registr		31. Date filed (Month, Day, Mehl)	AN 2027 Reg	BAH istrar's Signature				2 S.	Atwo	od Rd.,	Bel	Air, M	D 2101	4

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			For State of Ma	aryland /		rtment of H t <i>ificate of L</i>		-	giene Reg. No.	2007	23550
	600	1	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physicia /Medic		Thelma Remillard					July	18	2007	6:30p M
	Examin	er	4a. Facility Name (If not Institution, give street and number)			4b. City, Town, or		h		County of Death	
177	<u> </u>		Sunbridge Nursing Hom  5. Social Security Number 6. Sex 7. Ag	e (In yrs. last I	irthdou)	Elkton	If Under 24 Hrs.	8. Date of Bir		Cecil	place (State or Foreign
11: 3 to	Funeral Director		061-14-5938 1□ M 2X F 7. Ag Usual Residence of Decedent	89	Yrs.	Months Days	Hours Min.	May 9	y, Year)	Cou	ntry) MA.
	ryland how		10a. State 10b. County	10c. City, To	wn or Loc	ation					10d. Inside City Limits 1 ☐ Yes 2 No
	e Ma Ba-f s	cto	MD Cecil	Chesa	apeak	e City					
	or 2	Director	10e. Street and Number			10f. Zip Code				zen of What Cou	ntry?
	s 23a	ral	87 Deer Run		40.16	21915		116-17NI-	US	SA 14. Race - Americ	oon Indian
ထ္က	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Armed Forces?  1 □ Yes 2 □ If Yes, Give	ever in U.S.		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2XNo	ispanic Origin? (S in, Mexican, Puer Specify:	to Rican, etc.)		Black, White,	etc.
8	ural"	d by	Widowed 4 □ Divorced Year or Dates:	1.6	'a Dagad	ant's House Ossum	ation			WIL	ite
7	"nat	lete	15. Decedent's Education (Specify only highest grade completed)		a. Decedi (Give F life. D	ent's Usual Occup ind of work done o O NOT use retired	ation during most of wo. I)	rking	IOD. KII	nd of Business/In	idustry
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	filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	Maiden	Surname)	
lan	lid be lenta ked kic ev	To B	Almon Lawrence				Mabel	Rose	Syre	ett	
Maryland	shor and N s mai		19a. Informant's Name/Relationship (Type. Print)	19	9b. Mailin	Address (Street a	and Number or R	ural Route Numb	er, City o	r Town, State, Zip	o Code)
	and 2		Stevens L. Remillard - son			er Run,		ke City	MD	21915	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	20b. Place ceme	of Dispos tery, crem	ition (Name of atory or other place	e)	Date	20c. Lo	cation - City or Te	own, State
Ĕ	Pag ment ant; I		4 ☐ Donation 5 ☐ Other (Specify)	Metro		matory,		0/2007	Ba1	timore,	MD
Baltimore,	permit. Depart Import any in		21. Signature of Funeral Service Licensee Williams		22.	Name and Address Crematio 299 Fred	ss of Facility n Societ erick Ro	y of Mai	ylar imor	nd, Inc.	21228
r	100		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	I the death. De	o not ente						Approximate Interval Between
Ļ	Physician		Immediate Cause (Final disease or condition		2 Opat	to Hea	x + Disa	10			Onset and Death UeavS
	/Medical		resulting in death)	a consequenc		-u 11 -b)	01 010-0	4423	-		94115
ŀ	Examiner		Sequentially list conditions b.								
١,	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that Initialed events	a consequenc	e of):						
8	ecute and trans	Examiner	Cause (Disease of Injury that Initiated events resulting in death) Last C		o of):						
₹,09289	ficate be executed g physician and is the burial-transit	Ê	Due to (or as	a consequenc	e ory.						
87	cate I physi	edical	d								
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B	atten for u	cian	in the past 12 months?	2 Fetal dea		Ectopic pregnancy Other (specify)				Month	Day Year
P.O. Box	ne law requires that the death certific has been signed by the attending p	Physician/M	1 ☐ Yes 2 🗹 No 9 ☐ Unknown 9 ☐ Unknown			- (, ,, _,					
σ.	that ned b	by Pt	Part II. Other significant conditions contributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to t	the cause of death?
rds	quires n sign uld be	요	Dementia					1 🗆	Yes 2[	□ No 3 □ Pro	bably 4 Unknown
00	aw rec	Completed						24a. Was			opsy findings available
æ	The late has age 2	E O						auto perfo 1⊟ Yes	psy ormed? 2 ☑ No	death?	ompletion of cause of 2□ No
ţ	lan: rtifica stor, p	Be C	25. Was case referred to medical				26. Place of De	ath (Check only		1 100	20110
<u>-</u>	nysic direc	To E	examiner? 1   Yes 2   No   Hospital: 1   Inpatie	ent 2 ER/0	Dutpatient	3□ DOA Oth	er: 4 Nursing I	Home 5□Resi	dence (	6 □Other (Speci	fy)
0	ng Pl	ü	27. Manner of Death 28a. Date of Inju 1 ☑Natural 5 ☐ Pending (Month, Da		. Time of Injury	28c. Injur Worl		28d. Describe	how injur	y occurred	
sio	tendi eath. tor: A the fu	catic	2 Accident investigation				Yes 2 □ No				
Division or Vital Records,	al or At after d I Direct d in by	Certification:	determined   200. Flace of III	ury - At home, c. <i>(Specify)</i>	tarm, stre	et, factory, office		28f. Location ( City or To	Street an wn, State	d Number or Rur )	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use an	Medical C	29a. Certifier (Check only one)  1. Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination							
	To the within To the comp	Me	29b. Signature and title of certifier  Acholer S My			29c. Licens	e number 2332	2	29d. Dat	te signed (Month,	
,	2		30. Name and address of person who completed cause of or S · S · S + C+D E v M D  31. Date filed (Month, Day, Year)  32. Registr	eath (Item 23a	a) (Type, F				20		
			S. S. AtCHDEV IND	ar's Signatura	orth	of oule	35 E	exien '	11)	474	
	Sta Registi		32 Hegistr	ai s signature	fine	chi s					
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State Registrar

31. Date filed (Month, Day, Year) JUL 2 4 2007

Weense Lowe 32-Registrar's Signature

and manner stated.

eeure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7602 Belmi RD

29c. License number

29d. Date signed (Month, Day, Year)

Baltimer, MD 21236

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #18, perFH, G869, 7/24/07 TT Certificate of Death Reg. No. ( 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ornelia Kayner /Medical 202007 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital of Baltimore Baltimore City
If Under 1 Year | If Under 24 His. 5. Social Security Number 219-10-5012
Usual Residence of Decedent 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) 85 Yrs. 6. Sex **Funeral** Months 1 ☐ M 2 🖫 F Director 10b. County with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other thaumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore Funeral Director 10e. Street and Number 10g. Citizen of What Country? SRIGHTON 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: ò 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, 100 NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( noch Lewis ပ Lucy Randall 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, JOHENT 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 5151 Baltima JAI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Urinary Trad-Injection
Due to (or as consequence of): **Physician** /Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9∏Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ermer's dementia 1 Yes 2 No 3 Probably 4 Unknown Completed Seizure disorder 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe certificate Stroke 2DNo 1□ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident To the Hospital or Attenc within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 1 Grangiva ES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, Sinai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

Blac

10d. Inside City Limits

Approximate Interval Between Onset and Death

da

Year

Day

20, 2007

1 Nes 2 No

11:03 AM

Year

DHMH 17 Rev 1/2001

State

Registrar

Kapil-Gangwal.

JUL

31. Date filed (Month, Day, Year)

32. Registrar's Signature

HOSDITUS OF

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ms 23a or 28a-f shor

Examiner

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al Hygiene. other than

h and Mental H 7 Is marked of

permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 Is any injury or other trau.

Director

Funeral

by

Completed

Be

2

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ģ Completed Be 2 Certification: Medical

The law requires that the death certificate be executed physician a s the burialas page Hospital or Attending Physician: Director: within 24 hours a

To the Funeral C

completely filled i

Division or Vital Records, P.O. Box 68760.

State

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 1∐ Yes **XX**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify Residence 1 ☐ Yes XX No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation XX Natural Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0064313 July 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11722 Reisterstown Road M.D., Immediate Care Lorri Cobbins, Reisterstown, Maryland 21136

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUL 2 4

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 July 21, 10:05 PM Jane Raber Lois 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🔀 F Yrs 69 Pennsylvania 215-34-5021 1938 May 14, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 USA 134 Fairmont Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Mamied 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

**Physician** /Medical

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be in once.

Baltimore, Maryland 21215-0036

Director

Funeral

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death with the Maryland

**Examiner** 

signed by the a To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

LOIS RABER

_ 1			1							
Be Completed	15. Decedent's Edi (Specify only highest grad	de completed)	16a. Decedent's U (Give kind of life. DO NO	Jsual Occupa work done d Tuse retired)	ition uring most of work	king	16b. Kir	nd of Business	Industry (	
шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Meat Wra				Gro	cery St	ore	
Ö	17. Father's Name (First, Middle, Last)		11000		18. Mother's Nam	e (First, Middle				
70 B	Chalmer William	Smith, Sr.			Dorothy	Pearl N	1ille	r		
	19a. Informant's Name/Relationship (T	ype. Print)	19b. Mailing Addr	ress (Street a	nd Number or Ru	ral Route Numb	er, City o	r Town, State, 2	Zip Code)	
	Karen Amoroso / I	Daughter	4229 St.	Clair	Bridge	Road, C	Jarre	ttsvill	e, MD 2108	4
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ I	_	lace of Disposition ( emetery, crematory	Name of or other place		Date	20c. Lo	cation - City or	Town, State	
	4 □ Donation 5 □ Other (Specify		ington Na					ngton,	Virginia	
	21. Signature of Funeral Service Licens	see /	McCo	and Addres	s of Facility Ineral Ho	me, P.A	Α.			
		rge	1317	Cokes	bury Roa	d, Abir	ngdon	, Maryl	and 21009	_
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	n. Do not enter the r	mode of dying	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition	a NON SMALL (	CELL LUNG	CANCE	R				Onset and Death	
	resulting in death)	Due to (or as a consequent	uence of):							
_	Sequentially list conditions,	b	Janes of:							
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	derice or).							
xan	that initiated events resulting in death) Last	c Due to (or as a consequence	uence of):							_
<u>е</u>										
gi	24.0	d								
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna	incy				2	23d. Date of de	livery	
icia	in the past 12 months? 1 ☐ Yes 2 🗶 No	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		ic pregnancy (specify)				Month	Day Year	
hys	9 □ Unknown	9□Unknown								
Ϋ́	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	ng cause give	en in Part I.	23e. Did	tobacco u	se contribute to	o the cause of death?	
ed t						1 🗆	Yes 2[	□No 3□P	robably 4XIUnknow	/n
plet						24a. Was	s an opsy	24b. Were a	utopsy findings availab completion of cause of	le f
m (						perf 1∐ Yes	ormed? 2 X No	l death?	_	
ge C	25. Was case referred to medical examiner?				26. Place of Dea					_
To I	1 ☐ Yes 2 📉 No		ER/Outpatient 3□	DOA Othe	er: 4 🗆 Nursing H	ome 5 ☐ Res	idence	6 NOther (Spe	ecify) HOSPICE	
:io	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how injur	y occurred		
cati	2 Accident investigation 3 Suicide 6 Could not be		M		Yes 2 □ No		/=-			_
ertifi	4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac	ctory, office		City or To	(Street an own, State	d Number or H )	ural Route Number,	
Medical Certification: To	29a. Certifier 15 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my kno niner; On the basis of examina and manner stated.	wledge, death occur tion and/or investiga	rred at the tim ation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time	e cause(s) e, date and	and manner a d place, and du	s stated. e to the cause(s)	
Mec	29b. Signature and title of certifier	and married and di		29c. License			29d. Dat	te signed (Mon	th, Day, Year)	
	-			L	)437	25		7/23/	57	
	30. Name and address of person who	completed cause of death (Iten	n 23a) (Type, Print)						•	

DHMH 17 Rev 1/2001

State Registrar

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	-	epartment of F Certificate of			giene Reg. No. 2011	7 20665
Physici		1. Decedent's Name (First, Middle, Last	S	_ (-	ROHOBI	_	2. Date of De Month	. Day Ye	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	1	1	4b. City, Town, o	r Location of Death	*	4c. County of I	Death
Funeral Director		180=01=8033		(In yrs. last birtl		If Under 24 Hrs. Hours Min.	8. Date of Bir 7 (Month 10)	th 9	Birthplace (State or Foreign
yland low at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
ne Mary 8a-f sh otified	Director	MD. N/A		BALT	IMORE				1 Yes 2 □ No
th with the 23a or 2	al Dir	10e. Street and Number 2460 TERRA FIRM	A RD.		10f. Zip Code 2125			10g. Citizen of Wha	t Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If the XI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🖾 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black, V	American Indian, White, etc. BLACK
within 72 ho ene. than "natur the Medical.	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+ -0-	<del></del>	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire PROJECTIONI	during most of work d)	sing	16b. Kind of Busin	ŕ
uld be filed Aental Hygir rked other tic event, ti	To Be Co	17. Father's Name (First, Middle, Last) ERNEST A. ROHOBI	LT			18. Mother's Nam	e (First, Middle ANIELS	, Maiden Surname)	
12 should be h and Mental r is marked c	-	19a. Informant's Name/Relationship (T)			Mailing Address (Street				
is 1 and of Health item 27		LINDA V. ROHOBL.  20a. Method of Disposition			4233 PASCAL Disposition (Name of crematory or other pla		Date Date	20c. Location - City	
Pages tment of heart: If ite		1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		METRO	O CREMATORY	7-20			, MARYLAND
permit. Departr Importa		21. Signature of Funeral Service Licens	MAHTANOL)®	D. HIBI	ER. Name and Address				ME,,P.A RYLAND 21217
Se a l		23a. Part1. Fiter the disease, or comp shoot, ir heart failure. List only o	ications that caused t ne cause on each line	he death. Do no					Approximate Interval Between Onset and Death
Physician /Medical		Immediat 1 ause (Final disease or condition resulting in death)	aDue to (or as a	bleed consequence o					0.1.
Examiner	-e	Sequentially list conditions, if any, leading to immediate	Due to (or as a	denal consequence of	olcer				9 days
eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence o	f):				
ficate by physicisthe but so the but	edical		d						
he law requires that the death certified has reen signed by the attending onge 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date o Month	f delivery Day Year
w requires that the de reen signed by the s	by	Part II. Other significant conditions co	, -		the underlying cause giv occuded the				te to the cause of death?  Probably 4 □Unknown
	Completed	Gl bleeding from	n divert	zulosis	8years	ngo	24a. Was auto perfo 1∐ Yes	psy prio prmed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sumbox No
s certificate h	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	t 2□ FR/Out	patient 3 DOA Oth	26. Place of Dear			Coopie
or the Hospital or Attending Physician: In within 24 hours after death.  Or the Funeral Director: After this certificate completely filled in by the funeral director, p.g.	H-7	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	28b. Ti	me of 28c. Inju			idence 6 □Other ( how injury occurred	ъреспу)
To the Hospital or Attending B within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, fan (Specify)	m, street, factory, office			Street and Number own, State)	or Rural Route Number,
ne Hospi 124 hour ne Funer	Medical (	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	sician: To the best of iner: On the basis of and manner state	examination and	death occurred at the ti /or investigation, in my	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manne , date and place, and	er as stated. I due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	anim	n/ N	29c. Licens			29d. Date signed (A	
(1)		30. Name and address of person who c	anno, I	ath (Item 23a) (1	vpe, Print)	5 000		7/18/201	7
54		Sahar Koha	inim, m	D. H	ype, Print) and Hos	pital, B	altimo	e MD	
Sta Registr		31. Date filed (Month, Day, Year)  JUL 2 4	32. Registrar 2007	s Signature	Sporte	1			

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William L. Stratton 1- For State Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Da July 21, 2007 0658 hrs Medical Examiner William Lee Stratton 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University of Maryland 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs, last birthday) 5. Social Security Number Foreign Country Maryland 6. Sex **Funeral** Months Days Hours 217-54-4745 09/04/1947 Director 1X M 2 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 10a. State Yes 2 X No s 23a or 28a-f show e notified at once. Maryland Baltimore City Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland real of Health and Mental Hygiene. anti- of Health and Mental Hygiene anti- filten 27 is marked other than "natural", or items 23a or 28a-f sho 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 204 Harmison Street 21223 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. Funera 11. Marital Status Armed Forces? White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes White Specify. f Yes, Give Year Vietnam Yes 2 X No specify: Divorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 12 Repairman Appliance Company 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fletcher Be Arthur Irene 2121 Lee Stratton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ပ Arthur Lee Stratton - Father 6917 Bird Wood Avenue Middle River, Maryland 21220 2 t of Health are. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Garrison Forest, MD 2007 Important: injury or otl Maryland Veteran Cemetery Donation 5 Other Specify 22. Name and Address of Facility permit. 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Hom 1407 Old Eastern Avenue PA Essex, Maryland 21221 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death di a a Atherosclerotic Cardiovascular Disease Complicated by Drowning Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED tending physician a UNPENDED 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Dav Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) To the Hospital or Attending Physician: The law requires that the death ned by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 V Unknown ρ ۵ Chronic alcohol abuse Completed 24b. Were autopsy findings available Division of Vital Records, 24a, Was an has been autopsy prior to completion of cause of performed? death? No 2 1 V Yes ✓ Yes 2 No page 26.Place of Death (Check only one) 25 Was case referred to medica Be examiner? Hospital: Other 4 Residence 6 Nursing Home 5 Inpatient 2 🗸 ER/Outpatient 3 this 1 V Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28b. Time of Injury 27. Manner of Death After Subject drowned Certification: FOUND: Yes 2 V No Natural Pending 24 hours after death. Funeral Director: the Jul 21, 2007 0630 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by or Town, State) Lombard St./Stockton St., Baltimore, MD 3 Could not be Suicide (Specify) Pond Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 22, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brasseli, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

**DHMH 17 Rev 1/2001** OCME 2006

Registrar

**OCME** 

ORIGINAL

			For	State of Ma	,		of Health and	Mental Hy	giene	3 63 63 77	71 71 74 PM
			1 - State Registrar		C	ertificate	of Death		Reg. No. (	2007	2300
	Physicia	×	1. Decedent's Name (First, Middle, La.	st)				2. Date of De		_ Year	3. Time of Death
	/Medic		William Andrew S	Selig, Sr.				July 2	o, 200	)7	6:15 A™
	Examin		4a. Facility Name (If not institution, giv	·			vn, or Location of Deat	h		ounty of Death	
<b>B</b>			Manor Care Health	Services		Rossv	rille			Ltimore	
	Funeral		Social Security Number     6. S		e (In yrs. last birtho	Months   D	ear If Under 24 Hrs. ays Hours Min.	(Month, Da	rth ay, Year)	9. Birthp Cour	lace (State or Foreign
	Director		213-07-9391	IQM 2□F	92 Yrs			06/20/	1915	Mary]	
	nd •		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	Location		·		1	0d. Inside City Limits
	aryla shov	ř				Location				Ι.	1 ☐ Yes 2 ☐XNo
	8a-f	Sct	Maryland Baltimon	re	Essex						
	vith t	Funeral Director	10e. Street and Number			10f. Zip Co				n of What Cour	ntry?
	ath v	rai	358 Miles Road	1		2122			U.S.		- Ladina
	er de Item:	nue	11. Marital Status	12. Was Decedent   Armed Forces?		If Yes, specity	t of Hispanic Origin? (S Cuban, Mexican, Puer	pecity Yes or No to Rican, etc.)	0- 14	<ul> <li>Race - Americ Black, White,</li> </ul>	
2	s aft	by F	1 ☐ Never Married 2 ☐ Married  State  Widowed 4 ☐ Divorced	1 ☐ Yes 201 If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🔀	No Specify:		s	pecify: Whi	ite
200	hour tural al Ex		15. Decedent's E		16a De	cedent's Usual O	ecupation		16h Kind	l of Business/Inc	
Ċ	n 72 "na enic	Completed	(Specify only highest gra	ade completed)	(6	ive kind of work a e. DO NOT use n	lone during most of wo etired)	rking	Tob. Talla	or business/in	dudify
7	withi ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5	+)	mist	,		Stee	el Mill	
7 3	filed Hygi ther		17. Father's Name (First, Middle, Last	)			18. Mother's Nar	ne (First, Middle			
2	d be ental ced c	o Be	Albert Selig				unk.				
<u></u>	shoul od M marl mati	2	19a. Informant's Name/Relationship (	Type. Print)	19b. M	ailing Address (Si	treet and Number or Ri	ural Route Numl	per. Cifv or 1	Fown, State, Zip	Code)
2	nd 2 s Ith ar 27 is trau		William Andrew Se				Road, Balti				*
บ์	tem Hea tem other		20a. Method of Disposition		20b. Place of D	sposition (Name	of	Date	20c. Loca	ition - City or To	own, State
2	ages ent of t: If i		1 ABurial 2 □Cremation 3 □ 4 □Donation 5 □ Other ( <i>Specii</i>			crematory or othe	Gard 07/2	3/2007	Bol 7	Air, Man	cyland
Dallillor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Me Loal Examiner must be notified at once.		21. Signature of uneral Service Lice		betati						
Ď	Dep any any one		1 and			1407 01	dress of Facility Bruzdzinsk d Eastern	1 Funer	Eccor	me, P.A. Z Marvi	land 21221
	-		23a Part Enter the disease, or com- spock, or heart failure. List only	plications that caused	the death. Do not					Y, Mary	Approximate Interval Between
	Dhysisian		Immediate Cause (Final			benen	•				Onset and Death
<i>,</i>	Physician /Medical		disease or condition resulting in death)	a	a consequence of):	ie meen	<i>a</i> ) < .				
	Examiner			240 10 (01 40	a						
	Fe.	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as	a consequence of)						
٠,	uted d ansit	E I	Cause. Enter Underlying Cause (Disease or injury								
<u>,</u>	exec n and ial-tra	Examiner	resulting in death) Last	Due to (or as	a consequence of):						
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8	ificat g phy as th	edi									
Š	n cert endin use	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		∩□Estania succe			23	d. Date of delive	ery
٥	deatl e atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at	2 ☐ Fetal death time of death	3 ☐ Ectopic pregr 5 ☐ Other (speci				Month	Day Year
5	t the by th ache	Physician/Me	9 ☐ Unknown	9□Unknown							
Ų.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to death b	- ,	_	e given in Part I.	23e. Did	tobacco use	e contribute to the	he cause of death?
cords,	quire an sig uld b	Completed by	Longstive L	leart 1	Tae WY	٤.		1 🗆	Yes 2	No 3 ☐ Prob	pably 4 Unknown
ຽ	aw re s bee	Jeto	`					24a. Was	s an	24b. Were auto	psy findings available mpletion of cause of
ב	The la	шo						perf	ormed?	death?	
N I G	an: 7 tificat tor, pa		25. Was case referred to medical				26. Place of De	1 Yes	2 No	1 ☐ Yes	2 No
>	ysicia s cer direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpa	tient 3 DOA	Other:	forme 5 ☐ Res		Other (Specif	5/)
ō	a Ph er thi eral (		27. Manner of Death	28a. Date of Inju	ry 28b. Tim		Injury at Work?	28d. Describe			<i>y</i> /
5	nding th. r: Aft	iğ.	Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)   Inju	M	1 ☐ Yes 2 ☐ No				
DIVISION	Atte ector by th	Hice	3 Suicide 6 Could not b 4 Homicide determined	Zoe. Flace of inju	Iry - At home, farm	street, factory, o	ffice	28f. Location	(Street and	Number or Rura	al Route Number,
5	s afte	Certification:	4 El Torriloide	building, et	o. (Opecity)			City or 10	iwn, State)		
	e Hospital or Attending Physician: The lav 24 hours after death. Euneral Director: After this certificate has letely filled in by the funeral director, page 2:	cal					the time, date and plac				
	24 e Ft	ģ	(Check only 2 Medical Example one)	miner: On the basis o and manner sta		n investigation, in	my opinion, death occ	urred at the time	, date and p	nace, and due to	o trie causé(s)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bakuppod Rd

29c. License number D56979 

7-05565		Please Type or F						ie.	
erence Samps		- For State Of	Maryland / Depar			ı ivlental Hyç	giene	201	17 2356
		legistrar		ificate of D	eain		Reg. N	0.	2 Time of Death
Physicia le-**∽al Exami	_	1. Decedent's Name (First, Middle,Last) T	errence Kochele		m Rol	<u> </u>	Month Day July 20, 2007	/ Year	3. Time of Death 1513 hrs
		4a. Facility Name (if not institution, give stre 818 West Saratoga Street	eet and number)		City, Town, or L	ocation of Death		40. County of Doub	1/A
Eunoral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	f Under 1 Year	If Under 24Hrs.	8. Date of Birth(M	M/DD/YYYY) 9. Bit	• 1
Funeral Director				110	Months Days		0-201	Forei	an
Birector	ļ		2× F	4 Yrs.			DEP1. 30,	1907	ountry) MARYLAND
. <u>A</u>		Usual Residence of Decedent  10a. State 10b. County	10c City 7	Town or Location					10d. Inside City Limits
w any		AAA G	Too. Sity,	own or Location	2.		- a.	- 1	1 XYes 2 No
Maryland 28a-f show	ġ	YIAKYLANDI N/	A	1.0	( )HL	TIMOR	F 0/1	Citizen of What Cou	
Mary r 28a	Directo	10e. Street and Number			)f. Zip Code		109. 0	ilizen oi vvnat cou	iriti y ?
ith the 1 23a or notifie		818 W. SAK	ATOGA ST	REET		2120		USA	}
n with	Funeral		. Was Decedent Ever in U.S Armed Forces?			panic Origin? (Spe Mexican, Puerto R		14. Race - Amer White, etc.	rican Indian, Black,
deati or ite	.5	1 Never Married 2 Married 1	Yes 2 No				,	10	
after al", iner	by		Dates:		s 2 No			Specify:	LACK
10urs natur 'Xam	p	15. Decedent's Education (Specify only h	, ,			on (Give kind of wo DO NOT use retire		o. Kind of Business	/Industry
6 1721 an "i	jet	Elementary/Secondary (0-12)	College (1-4 or 5+)	6				p. 1-	- Arri
within er th	Completed	$\sim$	VRS	$\mathcal{O}$	ECRE			SUSINES	S OFFICE
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f shrent, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)	7	001		18.Mother's Name (	First, Middle, Maid	en Surname)	
D 21215-0036 should be filed within 77 and Mental Hygiene. 7 is marked other than natic event, the Medical	o Be	USCAR	151	19b. Mailing Ad	Idaaa (Chara	HELE!	U .	City or Town, State	THEUS
D 2 Shoul and N affe	۲	19a. Informant's Name/Relationship (Type,		21/ A I	- V	and Number of Ru	- n		
re, MD s 1 and 2 sho of Health and of item 27 is		HELEN SAMPSO 20a. Method of Disposition		lace of Disposition	(Name of cert	netery.		c. Location - City o	<u>MD 2 / 230</u> r Town, State
of Health		1 Surial 2 Cremation 3		rematory or other				1 -	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than or other traumatic event, the Medical		A Dopation 5 Other Specify:	a // MT	ZIONC	EMETE		26-01/	-ANSDO	UNE MP
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee	6//	22. Nam	e and Address	of Facility B	ROWN J	R. FUN	ERAL HOME
ED 8 G E E		flague vai	Konne	2/3	10 N.	FULTON	AVE. B	ALTO, MY	0.21217
Physician		23a. Part I. Effer the disease, or complicat failure. List only one cause on each li		Do not enter the n	node of dying,	such as cardiac or	respiratory arrest, s	snock, or near	Approximate Interval Between Onset and
Medical xaminer			ntracerebral he						Death
		o condition resulting in death)	to (or as a consequence of)	):					
	<u>_</u> 4	Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence of	١٠					
	Examine	cause. Enter Underlying Cause	to (or as a consequence or	,					
Alu	xal	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence of	):					
executed an and all - transi		d							
- o .E.E	<u> </u>	X UNPENDED X A	#1,23a,PII,27,p	erME 0871	9/5/07	TT.			
68760, certificate be nding physic	Me	IF FEMALE.	3c. If yes, outcome of pregn	ancy	), 5, 0,			23d. Date of delive	ry
687 ertifi ding e as t	an	23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal		Ectopic pregnan	icy	Month	Day Year
Box 68760, edeath certificate be the attending physici of for use as the buring of the buring the buring for use as the buring for u	sic	1 Yes 2 No 9 ✓ Unknown	Pregnant at time of dea Unknown	5 Other	(Specify) _				
that the dated by the detached	Physician/Medical		ntributing to death but not re	sulting in the unde	erlying cause g	iven in Part I.	23e. Did tobac	co use contribute to	o the cause of death?
		Cocaine use			, 0		1 Yes 2	No 3 Pro	bably 4 Unknown
cords, F aw requires has been sign 2 should be	fed	waine asc					24a. Was an	24b. Were a	utopsy findings available
COFC law re has be	림						autopsy performed	prior to	completion of cause of
Records, The law requir ficate has been s, page 2 should I	Completed by						1 <b>✓</b> Yes 2	No 1 🗸	res 2 No
	Be	25. Was case referred to medical examiner?				of Death (Check o	nly one)		
Z iš išiģi	0	examiner?  1  Yes 2 No	I Impatient Z	ER/Outpatient 3	DOM			sidence 6 🗸 Oth	er: Scene
ion of Vi tending Physi eath. or: After this	ı.	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injur		_	28d. Describe how	injury occurred	
ion itend eath. tor:	agi	1 X Natural 5 Pending 2 Accident Investigation				res 2 No			
Division rs after death. al Director: Aled in by the ft.	ifi	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, street, f	actory, office b	uilding, etc.	28f. Location (Stree or Town, State		Rural Route Number, City
Div Hospital of 24 hours at Funeral L	Certification:	4 Homicide determined	(Specify)						
Hos 24 h Fur tely		29a. Certifier 1 Certifying Physician:	To the best of my knowledg	e, death occurred	at the time, da	ate and place, and	due to the cause(s)	and manner as sta	ated.
To the Hos within 24 h To the Fur	<b>Aedical</b>		the basis of examination ar d manner stated.	ng/or investigation					
- A - O	e l	29b. Signature and title of certifier			29c. Licens	e number	1 29	d. Date signed (M	onth Day Year)

Margarita Korell MD.

Mayme The Mull

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

July 21, 2007

State 31. Date filed (Month, Day, Year)
Registrar 1111 9 1 3 DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year ave 200 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) 4c. County of Death th timore 1120 Wing enter S CA Year If Under 1 f Under 24 Hrs. 8. Date of Birth (Month, Day, July 23, 5. Social Security Number In yrs. last birthday) 9. Birthplace (State or Foreign 1916 Days 1□M 🎖 🗆 F 90 Yrs. 172-03-0331 Pennsylvania Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Halethorpe Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5553 Ashbourne Road 21227 **USA**  Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Ownhome 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edmund F. Miller Catherine Baserman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray C. Strayer, Husband 5553 Ashbourne Road Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/21/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service Ujcensee

Thomas Gregor remation Society Of Maryland, Inc. 99 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ears Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ear 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, 900.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

**Director** 

i Hygiene. other than "natural", or items 23e or 28a-1 show vent, tre Medical Examiner must be notified at

filed within 72 hours after death

Baltimore. Maryland 21215-0036

Funeral Director

ģ

Completed

Be

Examine use as the burial-transit Be Completed by Physician/Medical o signed by the at d be detached fo Certification: To

so the Hospital or Attending Physician: The law requires that the death certificate be executed

been si should b

After this certific funeral director,

within 24 hours after death.

To the Funeral Director: Af

Division of Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

3 Probably 1 ☐ Yes 2 ☐ No

> 24a. Was an autopsy performed? Yes 2 No

1 Yes

25. Was case examiner? 2 No 1 Tes 27. Manner of Death
| Natural
| 2 | Accident 5 Pending

Hospital: 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3□ DOA 28b. Time of

28c. Injury at Work? 1 🗌 Yes 2 No

26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 No

29a Certifier

Medical

3 Suicide

4 ☐ Homicide

1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 M 332 0 Sonson

Maryland

State Registrar 31. Date filed (Month, Day, Year) 2007

investigation

6 ☐ Could not be



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

5

31. Date filed (Mont Registrar

one)

30. Name and add

29b. Signature and title

32 Registrar's Sign

and manner stated.

eted cause of death (Item 23a (Type, Print)

29d. Date signed (Month, Day, Year)

07-05605 Troy Simmons Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

roy Simmons	State	tment of		and N	Mental I	Hygiene <sub>Reg</sub>	No. 20	07 2367		
Physician		egistrar . Decedent's Name (First, Middle Last						2. Date of Death	Day Year	3. Time of Death
Medical Examine	r		mmons					July 22, 200	14c. County of Deal	0025 hrs
	4	<ul> <li>a. Facility Name (if not institution, given 10 N. Greene Street</li> </ul>	e street and number)	4	b. City, Tow Baltimo		ation of Dea	atn	4c. County of Deal	
Funeral	. 5	Social Security Number 6. Se	x 7. Age (In yrs. Ia:	st birthday)	If Under 1	Year	If Under 24	Irs. 8. Date of Birth	(MM/DD/YYYY) 9. B	rthplace (State or
Director	- 1		M 2 F 40	Yrs.	Months	Days	.Hours M	1 08 07	1966 Fore	ountry) MD
	_	Isual Residence of Decedent								10d. Inside City Limits
w any	1	0a. State 10b. County	10c. City,	Town or Locati						1 Yes 2 No
Aaryland 28a-f show at once.	┋┞	0e. Street and Number		altin	10f. Zip Co	ode		10	g. Citizen of What Co	
the Maryland as or 28a-f sh	5	116 N. Edgen	and Street	t	(	1122	29		USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	<u> </u>	1. Marital Status	12. Was Decedent Ever in U.S	S. 13. Wa	s Decedent	of Hispar	nic Origin? (	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
or items 23		1 Never Married 2 Married	1 Yes 2 No		Yes 2			orto radan, oto.,	Specify: B	ack
s after ral", or niner	⋧┝	Widowed 4 Divorced  15. Decedent's Education (Specify of	or Dates:	16a Deceden	t's Usual Oc	cupation	(Give kind	of work done	16b. Kind of Busines:	s/Industry
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working	ng life. D	NOT use	retired)	GICC	
5-0036 led within 7 Hygiene. I other than			avrs	Mas	er t		ber		OCH Er	nployed
15-0 illed w Hygie d othe		7. Father's Name (First, Middle, Last				18,	Mother's Na	ame (First, Middle, M	alden Surname)	,
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  International Treath and Mental Hygiene.  International Treath and Mental Hygiene.  The Committee of the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event, the Medical Examiner must be notified at once the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event the content traumatic event traumatic event the content traumatic event the content traumatic event traumatic event traumatic event traumatic event traumatic event traumatic event traumatic eve	9 -	19a Informant's Name/Relationship (	Type, Print	19b. Mailin	Address	(Street a	and Number	or Rural Route Num	ber, City or Town, Sta	te, Zip Code)
MD d 2 sho th and n 27 is	- [-	John L. Simm	ons (Father)	1161	1. Ed	gen	2000	St., Balt	imore, M	D alaay
re, MC s 1 and 2 s f Health an fritem 27	[	20a. Method of Disposition  1 Burial 2 Cremation 3		Place of Dispos crematory or ot		⊷of ceme	tery,	Date	20c. Location - City	II. m
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify		ruid	Kia	e	1 Facility 6	127107	Tikesu,	vices
Baltimo permit. Pag Department Important: injury or ot	1	21 Signature of Funeral Service Lice	Stoom o	ZZ.,	tuigr	1	Facility	eens tur	Sulto MD	21229
Physician	+	23a. Part I. Erfter the disease, or comfailure. List only one cause on e	plications that caused the death.	. Do not enter t	he mode of	dying, su	ich as cardi	ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
ledical aminer		Immediate Cause (Final disease a	Heroin intoxicati	on and c	ocaine	use o	complic	ating acute	asthma	Death
, annie		or condition resulting in death)	Due to (or as a consequence or	f): exacer	bation					
		Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	f):						14
1	EΙ	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	f):						1
O, s be executed sician and burial - transit			l							
be exe	gical	X UNPENDED	#2500,27,28a-f, p		9, 7/2	5/07 7	<u> </u>		23d. Date of deliv	(en/
Box 68760 e death certificate be the attending physical for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		etal death	3	Ectopic pr	egnancy	Month 23d. Date of deliv	Day Year
ox 6	Sicia	past 12 months?  1 Yes 2 No 9 Unknow	4 Pregnant at time of de	eath 5 C	ther (Speci	fy)				
	ᇍ	Part II. Other significant conditions	9 Olikilowii	esulting in the	underlying	cause giv	en in Part I	. 23e. Did to	bacco use contribute	to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stander death.  "al Director: After this certificate has been signed by liled in by the funeral director, page 2 should be detach.	≦							1 Yes		Probably 4 🗹 Unknown
rds, require been should	Completed							24a. Was autor	osy prior	autopsy findings available to completion of cause of
He law ate has age 2 s	티							1 🗸 Yes	rmed? death 2 No 1 ✔	
Vital R ysician: 1 ysician: 1 director, p	Be C	25. Was case referred to medical examiner?	Hospital:			10	Mhon	neck only one)	Residence 6 0	ther:
f Vit	의	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury	28b. Time of		JA	at Work?	lursing Home 5 28d. Describe	how injury occurred	
on of \nding Phy. th. r: After the funeral	ion	1 Natural 5 Pending	(Month, Day, Year) Fnd 7/21/2007	Fnd 10:	00 nm	1 Y	es 2 X No	o unk		
ivision  I or Attend after death. Director:	ificat	2 Accident Investigated Suicide 6 X Could not be a suicide 1 Suicide 1 X Could not be a suicide 1 X Co	28e. Place of Injury - At h	nome, farm, str		office bu	ilding, etc.	28f. Location ( or Town, S unk	Street and Number or State)	Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide determin	ned (Specify) unk							
	edical (	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of my knowled er:On the basis of examination	dge, death occ and/or investig	urred at the ation, in my	time, dat opinion,	te and place death occur	e, and due to the cau rred at the time, date	se(s) and manner as and place, and due t	stated. o the cause(s)
To 1 with:	Med	29b. Signature and title of certifier	and manner stated.				number		29d. Date signed	
		( le e 1)	e Hell	lou		O.C.N	Л.Е.		July 22, 2007	
./		30. Name and address of person wh	o completed cause of death (Itel	m 23a)	Chr4	Dalfina -	ro MD 3	21201		
Ø			tant Medical Examiner	111 Penr	Street, I	oaitimo	JIE, IVID Z	. 1201		
Sta Regist		31. Date filed (Month, Day Year) 2	4 2007 Kegistar's Signa	, K	board	100				

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2	Physic /Med		Darryl L			_					July 1	13, 2	2007	Year	7:15 p <sup>M</sup>
	Exami	ner	,	,	give street and numi	ber)				r Location of Death	1	40	c. County	of Death	-
55	Funeral	•	Joseph R 5. Social Security I			. Age (In y	rs. last birthday	Balt ) If Under			8 Date of Bi	n/	/a	9 Rirthol	ace (State or Foreign
~	Director	Н	216-84-0	627	1 <b>X</b> M 2□ F		46 Yrs.	Months	Days	Hours Min.	8. Date of Bi (Month, D May 31	ay, Year	961	Mary.	try)
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2	er dea	une	11. Marital Status		12. Was Deced Armed Ford	es?	1 U.S. 13	. Was Deced	dent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N	0-		e - America	
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Pa	ding Phys J. After this ( funeral dir	ü	27. Manner of Deat	5 Pending		Day Year)	28b. Time of Injury	f 28	Bc. Injury Work		28d. Describe				1 - 57 /
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	To the Hospital of Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only	1 Certifying	Physician: To the be	est of my kr	nowledge deat	h occurred a	at the tim	ne date and place	ansdowne	MD Causo(s)	and ma	nnor no oto	tod
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Thelma C. Siegfried 19,2007 July /Medical 3:43pm 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent Center Crofton Anne Arundel Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral**  Birthplace (State or Foreign Country) Days 1 □ M 2 🗙 F Months Hours Min. Director 85 279-12-9512 Cincinnati, Ohid Dec.9,1921 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County a or 28a-f show be notified at 28a-f show 10d. Inside City Limits Director Anne Arundel 1 ☐ Yes 2 XNo MD Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a must | 1548 Harrow Ave. 21114 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Specify: White 3 ₩Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ John Fricke Eleanor Kemper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Siegfried / Son 1548 Harrow Ave. Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 26 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Easton, MD. Woodlawn memorial Park 2007 21. Signature of Fune of Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA Certification: To this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation after death 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ď 1438DeJense Hu 5 31. Date filed (Month, Day, 2. Registrar's Signature Year) State 2007 4 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 20,2007 Year Harriet Stevenson 4:25pm м /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Mitchellville Collington Episcopal Life Care 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 1 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Year 1 ☐ M 2 🕱 F Director 521-05-6696 89 17,1918 Denver, Col. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location r 28a-f show notifled at show 10d. Inside City Limits 1 XYes 2 □ No Director MD Prince George's Mitchillville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Lottsford Road 10450 20721 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Insurance Co. 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur G. Swanberg ပ Harriet M. Shotwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred H. Barrett /Daughter 4000 Aqua Court Dunkirk, MD 20754 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 24, permit. Page Department of Important: If any Injury or 5 ☐ Other (Specify) Alexandria, VA. 4 Donation Metropolitan Crematory 2007 21. Signature V Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6 . 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiomyopathy /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Por in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 100 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No page 2 s has autopsy perform certificate 1 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only of 2**N**0 Hospital: Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

certificate be executed Box 68760. P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after upage...

To the Funeral Director: After the function of

who completed cause of death (Item 23a) (Type, Print) Anita Clayton MD. 31. Date filed (Month, Day, Year) State

30. Name and address of pers

(Check only one)

and title of confifier

29b. Signatu

1221 Merchantile Lane Largo, MD

32. Registrar's Signature

and manner stated

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

20774

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year )te lohn 8:30 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Smith's Edgewood
If Under Year | If Under 24 Hrs. Patricia County Hartord 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 87 Months Hours Min. 037-24-8833 June 24 Director I+a1 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits must be notified at Director Maryland Harford Edgewood 1 ☐ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1199 21040 Hanson Funeral United Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or iten Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: White 3 Widowed 4 □ Divorced Completed the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Barber 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stefano Potito ٩ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Stefano (San John Bordeaux 1703 Fallston, MD Ct. Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Highview Memorial Gdrs July 24, 2007 Fallston, 22. Name and Address of Facility Cremation Center Evens Foresal and Cremation Center 21. Signature of Funeral Service Licenses Forent Hill, MD 21059 Neuport Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to finitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or sels consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform 2 No 25. Was case examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 5 Residence 8 Other Specify S.R. 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours affer death.

To the Funeral Director: Affer this of completely filled in by the funeral director. Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

37

State Registrar 30. Name and address of person who completed cau

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23a) (Type, Print)

death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MFND TTFW/I perFHYS, C869, 7/24/07 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Linda L. Holcomb Shanabrough Day Year **Physician** .15 07 16 2007 21 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number) Maryland Baltimore Medical Center n/a 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2□F 227-62-5067 **Director** 61 <u>March 25 1946</u> VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 □ No PA Director York Stewartstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17895 Pond View Lane 17363 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Functional Analyst n/a <u>Health Insurance</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Cosby Lightfoot, Sr. Deloris Absher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. J. Shanabrough/husband 17895 Pond View Ln., Stewartstown, PA 17363
Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ★□ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Brown's Chapel Cem. 7/23/07 Dillwyn, VA 21. Mgnature of Funeral Service Licensee Bryan W. Cla 22. Name and Address of Facility Demmon Funeral Home of Dulaney VAlley, Inc. Clary 23a. Part1. Enter the disease, or complication, that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/ailure. List only one cause on each line. Approximate Immediate Cause 4 inal disease or confilion resulting in death) Left Physician middle Cerebrai /Medical Due to (or as a consequence of): Examiner 7 hours Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 295P 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed?

1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No in 24 hours after death.

E Funeral Director: A letely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29b. Signature and title of cortifler 29c. License number 29d. Date signed (Month, Day, Year) 2 16000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 22 GREENE BALTIMORE QAQISH SOUTH CLEMENT 31. Date filed (Month, Pay, Year

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Schir MACHER 2001 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Forest Haven Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🔀 Director 219-40-8876 64 March 27, Indiana Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Rockda1e 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3618 Hillmar Road 21244 United States of America Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ▼ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Filter Rite the Warehouse Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be lealth and Mental marked Thomas H. Wallace Evelyn M. Steele and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau Lisa M. Castellanos (Daughter) 3618 Hillmar Road, Rockdale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial PK 07/24/07 4 □ Donation 5 □ Other (Specify) Elkridge, Maryland 21075 21. Signature of Funer Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. an 8728 Liberty Road, Randallstown, Maryland 21133 MO1234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-tran Division or Vital Records, P.O. Box 68760, $ec{arphi}$ Due to (or as a consequence of): Physician/Medical as attending properties of IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 40nknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate ha death? 1 ☐ Yes 1□ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural
Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of c 29d. Date signed (Month, Dav. Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address AROLD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 6:50 AM Sheppard 2 O 200 Virginia Virgie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner BALT If Under 1 Year If Under 24 Hrs. AGNES HOSP 1 TAL Hrs. 8. Date of Birth (Month, Day, Year) 08 23 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min. 1□ M 2√□ F 91 215-16-1730 15 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 X Yes 2 □ No Director Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 'natural', or items 23a or dical Examiner must be r U.S.A. 21215 Funeral 3407 Parkington Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 5th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Gray Robert Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 3407 Parkington Ave, Baltimore, Md other t Blanche Garrett-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any Injury or conce. Metro Crematory Inc 7/23/07 Baltimore, Md 22. Name and Address of Facility March F/H West Signature of Funeral Service Lice 4300 Wabash Ave, Baltimore, Md 21215 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmed te Cause (Final isea) e or condition **Physician** Lnown 4100 /Medical Due to (or as a consequence ): Examiner DEUMON JAKA OWA Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Wunknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, SHEPPARD

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral I

completely filled

Medical

State Registrar 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

6 ☐ Could not be

Nacumqua

Year) 2007

Avenue

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

BALTIMORE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

201

2001

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

900 CATON

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tirhe of Death Month Dav Year **Physician** 9:57 P M SHAW JAMES 18 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDALLSTUWN BALTIMORE WEST NORTH HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1**X** M 2□ F Months October 14, Director 227-20-5836 1922 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 3a or 28a-f show t be notified at Maryland 1 ☐ Yes 2X No Director Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 5412 Old Court Road 21133 United States of America "natural", or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify Black Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Automotive 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James B. Shaw, Sr. Elizabeth Valentine ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Almeata Howell 8561 Woodward Drive, Richmond, Virginia 23236 (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State | Marial 2 | Cremation 3 | Removal from State | Cernetery, General Veterans Cem. | 07/26/07 | Owings Mills, MD. 21117 permit. Pages Department of Important: If its any Injury or o 21. Signature of Funeral Solice Licensee 22. Name and Address of Facilit Loring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133 161234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy death? 1 ☐ Yes 2 ☐ No performed 2 1 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 1 [9 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: ompletely filled in by the f

19 State

Registrar

LEUNARD RICHARDSON M.D. 31. Date filed (Month, Day, Year)

JUL 2 4

determined

4 Homicide

(Check only

29b. Signature and title of certifier



M-D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 OLD COURT ROAD RANDALLSTOWN MD 21133

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

057722

29d. Date signed (Month. Dav. Year)

18 2007

		1 - For State Registrar	State of Mary		partment of t <i>ertificate of</i>		,	gien Reg. N	000	22620	
19.35	. 14	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death									
Physic /Med		Stephen Joseph Scerbak							007 04:10M		
Exami		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center  4b. City, Town,				or Location of Death	son	4	c. County of De	ath altimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Months Days	der 1 Year   If Under 24 Hrs.   8. Date of Births   Days   Hours   Min.   (Month, Da Aug • 1			th year 1920 9. Birthplace (State or Foreign Country) Pennsylvania		
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		Usual Residence of Decedent  10a. State 10b. County	· 10	c. City, Town or	Location					10d. Inside City Limits	
	by Funeral Director	Maryland Baltimore Parkville								1 □Yes 2 No	
		10e. Street and Number	IIIOI C		10f. Zip Code			10g. C	itizen of What C	Country?	
		3511 Fondulac Road			21234			USA			
036 urs after dea al", or items xaminer m		11. Marital Status  1 Never Married  Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1∰ Yes 2 ☐ No If Yes, Give Year or Dates:	in U.S. 1	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No		pecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Wh Specify:		
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Exam	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. De	cedent's Usual Occup	pation	leim m	16b. I	Kind of Busines	s/Industry	
	Completed	Elementary/Secondary (0-12)	y/Secondary (0-12) College (1-4or 5+)		(Give kind of work done during most of working life. DO NOT use retired)			_	. a a		
	ខ	17. Father's Name (First, Middle, Last,		V	Welder	40 84-45	- /5: 1 10:-1-11			l Construction	
be de la la la la la la la la la la la la la	To Be	Paul (unk) Scerbak			18. Mother's Name (First, Midd (UNKNOWN)			ne, maiden Surname)			
re, Maryla s 1 and 2 should f Health and Mer ttem 27 is marke other traumatic						s (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
e, N 1 and Health em 27 ther tr		Victoria J. John			11510 Gle		, Glen		•		
Baltimore, Mispersit and 2 Department of Health is Important: If them 27 is any Injury or other tra once.		1 ☐ Burial 2 ☐ Cremation 23 ☐			position (Name of rematory or other pla		Date	20c. L	_ocation - City o	r Town, State	
Iltin Init. Parime artme briani Injury		4 □ Donation 5 □ Other (Specify) Hilltop Service Corp 7-20-0						Towson, Maryland			
Balti permit. Departr Importa any Inje		21. Signal ry of Funeral Struce Using 22. Name and Address of Facility McComas Funeral Home, P.A.  1317 Cokesbury Rd., Abingdon, Maryland 21009									
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between									
		Immediate Cause (Final								Onset and Death  1 DAY	
/Medical		resulting in death)  Due to (or as a consequence of):							1 2/11		
Examiner		Sequentially list conditions, if any, leading to immediate  b. ACUTE RENAL FAILURE  Due to (or as a consequence of):								11 DAYS	
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
<b>68 / 60,</b> Ifficate be executed g physician and as the burial-transit	xan	that initiated events resulting in death) Last	C OBST nsequence of):	STRUCTIVE FULMONARY D			SEASE 1		11 DAYS		
<b>68760,</b> fireate be expression and physician are the burial as the burial											
68/ tificate g phy as the	edical		d								
Hecords, P.O. Box The law requires that the death cert the has been signed by the attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	st 12 months?  2 \( \text{No} \)  No    \text{Industry}    A				23d. Date of delivery  Month Day Year				
S, F.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?			
<b>Hecords,</b> he law requires the has been signed ge 2 should be come.	d by						1 🗷	1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
Scord  aw require s been sign  s been sign  s should t	Completed						24a. Was				
The lav	mo					at pe		opsy prior to completion of cause of death?			
VITAL I siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death								
Of V Physic rthis or ral dire	2	Hospital Othor:						me 5 ☐ Residence 6 ☐ Other (Specify)			
ISION ttending death. ttor: After the funer	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time Injur	y Wor		28d. Describe I	how inju	ary occurred		
	icat	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, building, etc. (Specify)				M 1 Yes 2 No		8f. Location (Street and Number or Rural Route Number,			
	Certification:					City or T		own, State)			
To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the vithing the solution of	Ž	29b. Signature and title of optifier			29c. License number			29d. Date signed (Month, Day, Year)			
- Caput						D0059283 J			114.16,2007		
4+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RICHARD O. ADDO, M.D. 8415 BELLONA LANE TOWSON, MARYLAND 21204									
	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	10.00				Line of the Sec		
Regist		JUL 2 4	LUU/ Maria	0 15	Sperle						
DHMH 17 Rev 1/2	:001				-						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4:30 P. M **Physician** 100-18r lliam July KOYSTON 2007 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sunshine White Baltimore Count Acres Hall If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 1 M 2 ☐ F 217-18-6956 85 Director 8.1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Blackhorse **Funeral Director** Mariland Harford County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number States 2116 united Iroyer 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 M No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trayer Appliance Ctr. Owner Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Howard Trayer Mariam Lovisiah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Trayer Rd. Blackhoise MD. Mrs. Heidi Nash (Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or c 1 ☐ Burial 2 \*\*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Mariland Evans Eineral Chapel 16/7 24, 2007 22. Name and Address of Facility and Cremtim Center
Evans Fren Chrise and Cremtim 21. Signature of Funeral Service Licensee 3 Newport Dave, Forest HIII, MD 21050 23a. Part1. Ent. the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzhermer
Due to (or as a consequence of): years Dease **Physician** disease or condition resulting in death) /Medical month ostridirm Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the aftending physician and page 2 should be detached for use as the burial-transit POXIA Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 4M Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 ☐ Yes 2 ER/Outpatient this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 □ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

Division or Vital Records, P.O. Box 68760, or Attending Physiclan: completely filled in by the funeral director, death. Director: To the Hospital within 2.

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier Laigh 29c. License number

29d. Date signed (Month, Day, Year)

D0054513

7/23/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marrisville RJ Jarressville, MD. 3718 Mar Grai 31. Date filed (Month, Day, 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29a Certifier

				ype or Prin									_	ble.		
			1 _ State	State of Ma	ıryland				lealth a Death	and IV	iental Hy	gien Reg. N		(3 **)	0.0	-00
		6-	Registrar  1. Decedent's Name (First, Middle, Last)				imoa		Doain		2. Date of De	eath	Ben and		3. Time of	Death
	Physici /Medic		Edsel Ford Thorpe								July 1	9, 2	2007	Year	10:	25AM
	Examin		4a. Facility Name (If not institution, give st 3326 Paine Street	reet and number)				t, Town, or	r Location o	of Death		40	c. County N/	of Death A		
	Funeral Director		5. Social Security Number 215–24–5271 6. Sex 1₺€	м оП =	(In yrs. las 79	st birthday) Yrs.	If Und Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Feb. 1	rth ay, <i>Year</i> <b>0,1</b> 9	28	9. Birthp Coun Mary	lace (State o try) <b>land</b>	or Foreign
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside C	itv Limits
	ne Maryla 8a-f sho otified at	Director	Maryland N/A			altim	ore								<b>XX</b> Yes	2 🗌 No
	th with the 23a or 2 ast be no	al Dire	3326 Paine Street					ip Code 21211				10g. C	itizen of V US			
2-0036	be filed within 72 hours after death with the Maryland that lygiene.  d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1  1 Never Married 2 Married 3 Widowed Divorced	2. Was Decedent E Armed Forces? 1 Tyes 2 □ N If Yes, Give Year or Dates:			Was Dec f Yes, sp 1 □ Yes		lispanic On an, Mexicar Specify:	gin? (Sp i, Puerto	ecify Yes or N Rican, etc.)	0-	Blac	ace - American Indian, ack, White, etc. hify: White		
21215-0	within 72 ho ene. <b>than "natu</b> <b>he Medical</b>	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation co <i>mpleted)</i> College (1-4or 5-			lent's Us kind of w DO NOT echa	ork done use retired	ation during mos d)	t of work	ing			usiness/Industry Cyland Administrat		ation
Maryland 2	0 m 0 %	To Be Co	17. Father's Name (First, Middle, Last) Linwood Thorpe			Ivi	еспа	iiic	18. Mothe	_	e (First, Middle Bryant					
Mary	and 2 shor ealth and № n 27 is ma	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - (Company of the place)														
altimore,	Pages 1 anent of He ant: If item												City or Town, State		and.	
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service License	3. We	ns	s) 22	Burg 3631	and Addre ee-He Fall	ss of Facilit Enss—S S Roa	eitz ad, E	z Funer Baltimo	al E	Home, Mary	Inc land	. 2121	1
4	Physician /Medical Examiner	ľ	23a. Part1. Enter the disease, or complic shock, or heat failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a	vn s a conseque	cnce of):			ng, such as	cardiac	or respiratory a	arrest,			Approximat Interval Ber Onset and	te tween Death
68760,6	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a												
.O. Box	or Attending Physiclan: The law requires that the death certificate be ther death.  Director: After this certificate has been signed by the attending physicia in by the funeral director, page 2 should be detached for use as the burn	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ac. If yes, outcome per 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal d	leath 3	Ectopic Other (	pregnancy specify)	y					te of delive		Year
rds, P	w requires that the d been signed by the should be detached		Part II. Other significant conditions cont	/			nderlying	cause giv	en in Part I				use cont		he cause of o	
al Records,	siclan: The law red s certificate has bee irector, page 2 shou	The state of the s										mpletion of o	available cause of			
Vita	Was case referred to medical examiner?    25. Was case referred to medical examiner?   1   Yes   2   No   No   No   No   No   No   No															
on or	ding Phys h. After this funeral dir	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 2	28b. Time of Injury		28c. Injur Wor			28d. Describe				y/	
Division or	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	ıry - At hom c. (Specify)	ne, farm, str	eet, facto	ry, office			28f. Location City or To			per or Rura	al Route Nur	nber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) Certifying Phys	ician: To the best of er: On the basis of and manner sta	examination	ledge, deatl on and/or in	h occurre vestigati	d at the ti	me, date ar opinion, dea	nd place, ath occur	and due to the	e cause( e, date a	s) and mand place,	anner as s and due to	tated. o the cause(	s)
	To the within To the comp	Me	29b. Signature and title of certifier	~			2	9c. Licens	e number	28		29d. D	ate signe	d (Month,	Day, Year)	フ
,	13		30. Name and address of person who col	poleted cause of de	eath (Item 2	23a) (Type, /es) 13	Print)	Depel	Avenue	Sv.7	6 22 Be	IT:	rope	mo	7 212	7)5
(A)	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra												

			1 - For State Registrar	State of	Marylar		artmen <i>rtificat</i>			and M	,	giene	0 0 0 77	23683
			1. Decedent's Name (First, Middle, Li	ast)							2. Date of De	ath	-	3. Time of Death
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	Exami		4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location o	f Death			. County of Death	1 1100 1
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	Funeral		, , , , ,	Sex 7 13X M 2 □ F	. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthp Coul	place (State or Foreign
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	land		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation						1	10d. Inside City Limits
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	288 1000	Director	10e. Street and Number	ita		Bel Air	10f. Zip	Code				10a. Cit	tizen of What Cour	ntry?
	38 o		203 East MacPhail	Road				210	114			•	USA	•
	d within 72 hours after death with the Maryland jiene. rithan "natural", or itams 23a or 28e-f ehow trithan "natural", or itams 23a or 28e-f ehow the Modical Examinar must be notified at	Funeral	11. Marital Status	12. Was Deced	ent Ever in L	J.S.   13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - Americ	
စ္	after or its	F	1 Never Married 2 Married	Armed Ford 1 Types 2 If Yes, Give	□No		_			, Puerto I	Hican, etc.)		Black, White,	etc.
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Maryland 21215-0036	2 should be and Mental is marked aumatic ev	5	Edward (nmn)  19a. Informant's Name/Relationship	Thomas Type, Print)	-	19b. Mailir	na Address	(Street a					or Town, State, Zip	<u> </u>
Ž	P 등 등 등		Susan Yeagley/Dau	ghter							, Litit			_
re,	f Healifern other		20a. Method of Disposition			Place of Dispo cemetery, crei	sition (Nan	ne of	a)	D	ate	20c. Lo	ocation - City or To	own, State
Baltimore,	permit. Pages 1 Depertment of H Important: if ite any injury or ot		1 St Burial 2 □ Crefitation 3 5 4 □ Donatjon 5 □ Wher (Speci	□Removal from St fv)	are	el Air	•		· 1	07-2	3-07 E	e ]	Air, Mar	vland
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S, D	that hed b	by Pt	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco u	use contribute to the	ne cause of death?
rds S	n sign	Q D	dealites								101	/es 2	□No 3□Prob	ably 4 Unknown
00	w require s been sis	Completed	che hann'								24a. Was	an	24b. Were auto	psy findings available
æ	The la	mo									autop	rmed?	prior to con death?	mpletion of cause of
ta	an: tifice tor. p	0	25. Was case referred to medical	- 333890.001					26 Place	of Death	1 ☐ Yes  Check only o	2 1No	1 Yes	25 No
<u> </u>	Physician: this certifice ral director, p	ToB	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 _ Inp	atient 2 🗆	ER/Outpatien	t 3 🗆 DO	A Othe					6 □Other (Specifi	ivl
ō	ig Ph ter th	<u> </u>	27. Manner of Death	28a. Date of		28b. Time of Injury		8c. Injury Work		A	8d. Describe i			97
Ö	Attending r death. ector: After by the funer	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n	Day (dar)	injuty	М		.r ∕es 2□N	lo				
Division of Vital Record	는 를 들는	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	Injury - At h	ome, farm, str fy)	eet, factory	r, office		2	8f. Location (5 City or Tox		id Number or Rura )	d Route Number,
	he Hospital n 24 hours a he Funeral ( pletely filled	edical	29a. Certifier   TS Certifying Pl (Check only one)   2   Medical Example	nysician: To the b miner: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred vestigation,	at the tim in my op	e, date and pinion, death	l place, a h occurre	nd due to the d d at the time,	cause(s)	and manner as si place, and due to	tated. the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier			-	29c	License	number			29d. Dat	te signed (Month,	Day, Year)
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11	+ / V		30. Name and address of person who				Print)						,	
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	Sta Registr		31. Date filed (Month, Day, Year)	4 2007 ►	istrar's Signa	ature	100	A.0						

		·	For State Registrar		State of Ma	21 y 10111				Death		Reg. No	711111	2.0	3684
	Physicia	an	1. Decedent's Name		TRIMPE	R					2. Date of Dominth	eath Da   <b>9</b>		3. Time	of Death
	/Medic		4a. Facility Name (If	not institution, gi	ve street and number)			4b. City	, Town, or	r Location of Deatl	,		County of Deat		
		- 12			LAND MEDICI				3ALT	TIMORE  If Under 24 Hrs.		-th-	o Bi-ti	nala an /Cta	to an Familia
l	Funeral Director		5. Social Security No. 219-12-3. Usual Residence of	348	Sex 7. Age 7. Age 7. Age		ast birthday) 2 Yrs.	Months		Hours Min.	8. Date of Bi (Month, D		MD 9. Birth	untry)	te or Foreign
	yland low at		10a. State	10b. County		10c. City	, Town or Loc	cation					-	10d. Inside	City Limits
	e Mar Sa-f sh tified	ctor	MD	Anne Ar	undel	G1e	n Burn	ie							es 2 🔼 No
	vith th	Funeral Director	10e. Street and Nur					10f. Zi	p Code				izen of What Co	untry?	
	eath v	eral	1010 Hil 11. Marital Status	Itop Rd.	12. Was Decedent	Ever in U.:	S. 13. V	Vas Dece	210 edent of H	60 lispanic Origin? (S an, Mexican, Puer	pecify Yes or N	USA o-	14. Race - Ame	rican Indian	,
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun		ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			fYes, sp □Yes		an', Mexican, Puèr Specify:	to Rićan, etc.)		Black, White Specify: Wh		
5	72 hou	Completed	(Spec	15. Decedent's E ify only highest gi	ducation ade completed)		16a. Deced	lent's Us	ual Occup	oation during most of wo	rking	16b. K	ind of Business/	ndustry	
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2	e filed al Hyg other vent, t	Be C	17. Father's Name (	First, Middle, Las	t)					18. Mother's Nar	me (First, Middle	e, Maider	Surname)		
yland	2 should b and Menta Is marked raumatic e	To	Emory Wa							Susan K					
Mar	d 2 sh th and th and ?7 Is m traum	4	19a. Informant's Na Mrs. Mary				1	_		and Number or Ri		-			
	s 1 and if Health item 27 other tr		20a. Method of Disp	osition		20b. P	lace of Disposemetery, cren	sition (Na	me of	h Lane,	Date		ocation - City or		9
	Pages nent of ant: If its ary or o			☐Cremation 3   5 ☐ Other (Spec	Removal from State	1	n Have	-		1.111 37	07 07	Gle1	n Burnie	. MD	
baltimore,	permit. Departr Importa any Inji		21. Signature of Fu	neral Service Lice	пѕее		- 4			ess of Facility		Seco	nd Ave.	SW	
	<u>0</u> 0 = ≈ 0		23a Parti Enter ti	he disease or cor	nolications that caused	MO14				Funeral			Burnie,		
	Physician	er v	shock, or hea Immediate Cause ( disease or condition resulting in death)	Final	nplications that caused y one cause on each lin a. SEPS IS				w 01 dj.:			arrost,		Onset a	mate Between nd Death YS
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	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	injury _ast	cDue to (or as	a consequ	uence of):								
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0	rtificati ng phy as the	Medical	IF FEMALE:												
Š O	sician: The law requires that the death cert certificate has been signed by the attendin rector, page 2 should be detached for use a	Physician/N	23b. Was deceden		23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Feta	Ideath 3□		pregnanc	у		i	23d. Date of del Month	ivery Day	Year
5	the de y the a iched t	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9☐Unknown	t time of a	eatti 5L	Other (	specify)						
7	s that gned b	by Pr			contributing to death b		ulting in the ur	nderlying	cause giv	ven in Part I.			use contribute to	the cause	of death?
ä	equire sen sig	ted k			Y DISEASE						1 [	Yes 2	No 3∏Pi	obably 4	Unknown
Hecords	e law I has be	Completed	ATRIAL		ATION						24a. Wa	s an opsy formed?	24b. Were at prior to death?	itopsy findii completion	ngs available of cause of
VIIall	n: The fficate ha		HYPERTE 25. Was case refer							26. Place of De	1∏ Yes	2 N		2□ No	
	(O :=	o Be	examiner?	,	Hospital: 1 Inpatie	ent 2	ER/Outpatien	t 3 🗆 🗈	OA Oth	or.			6 ☐Other (Spe	cify)	
DIVISION OF	r Attending Phys er death. Irector After this i by the funeral dii	on: T	27. Manner of Deat	h 5 🗌 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury		28c. Inju		28d. Describe	how inju	ry occurred		
SIO	Atteriding r death. ector: After by the funer	catio	2 Accident	investigati 6 ☐ Could not	be 28e Place of ini	uny - At ho	ome farm etr	M eet facto		Yes 2 □ No	28f Location	(Street a	nd Number or Ri	ural Route	Vumber
2	0 = 0 =	Certification:	4 ☐ Homicide	determine	building, et	c. (Specify	y)	coi, idoic	ry, onice			own, Stat		ilai rioute i	varnoer,
	To the Hospital or Attendiwithin 24 hours are readin. To the Funeral Director A completely filled in by the fi	Medical C	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis o and manner st	f examina									se(s)
	To the I within 2. To the I complet	Me	29b. Signature and	title of certifier				2	9c. Licens	se number		29d. Da	ate signed (Mont	h, Day, Yea	ar)
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	15				completed cause of d				r RA	AI TIM-OF	MARY.	2/46	21201		
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	Registr				- 10			. P							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Phyllis, Uther back 2. 03AM 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9-18-1936 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 70 Pennsylvania **Director** 164-30-3662 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Columbia Director Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10818 Hunting Lane 21044 U.S.A. Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Howard County School Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of Assessments is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvin A. Hicks Catherine Statler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any Injury or other trau 10818 Hunting Lane Columbia, MD 21044 Harry K. Utterback (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Grove Cemetery 7-21-2007 4 ☐ Donation ; 5 ☐ Other (Specify) Chambersburg, PA 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin KNolls Road 21. Signature of Funeral Service Lie nsee Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List my one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 48 123 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Keral if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hean connect to the Funeral Director. PTIC SHOCK resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Preumonia Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 2 PNO Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: မ 1 Yes 2 No 1 ⊠Jnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🖎 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

State Registrar 31. Date filed (Month, Day, Year)

10724 little Patriexeni

Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmad

Marie & April

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:30 A M **Physician** Stanley T. Vocke, Jr July 20,2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2923 Summit Avenue Carney Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** X☐M 2□F 219-20-6344 80 Yrs Director Feb. 6, 1927 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show 10d. Inside City Limits MD Baltimore Carney 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2923 Summit Avenue 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married Marned ö 1 ☐ Yes 2X No ģ Specify White 3 Widowed 4 Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pipe and Steamfitters Elementary/Secondary (0-12) College (1-4or 5+) Plumber/Steamfitter 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be find Mental h Stanley T. Vocke, Sr Mary Anna Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therese Vocke-spouse 2923 Summit Avenue-Carney, Maryland 21234 tsm 27 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Dularey variey Maioriai Cardens 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State July 24,2007 Timonium.Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
EVANS FUNERAL CHAPEL 8800 Harford Road ondai Parkville, MD 21234 AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CancER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to for as a consequence off Examin physician and s the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably been si 1 ☐ Yes 2 ☐ No 4 ∐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 1 ☐ Yes 2 📉 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Dome Sesidence 6 Other (Specify)
28d. Describe how injury occurred 4 Nursing Home To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury М 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause signal manner as stated.

| Medical Examiner: On the basis of examination and/or investment in the cause of examination and or e 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed Month, Dey, Year) WhewillE, Mn. 21093 death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day)

32. Registrar's Signature

Baltimore, Maryland 2121

Box 68760,

P.O.

Division of Vital

OKE

Stanley

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** July 1 Bay Ena May Walker 0606 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Olney Montgomery General Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Feb. 9, Director 63 1944 Jamaica 077-62-7152 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event. ... 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Silver Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20905 U.S.A. 15321 Beaufort Place Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **X**No 1 ☐ Yes 2 🛣 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Courtney Petrie Iris Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15321 Beaufort Place Silver Springs, MD 20905 Ray Walker (Son) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Marylarid Nationalic 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-28-2007 | Laurel, Maryland Cemetery of Funeral Service 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 5555 Twin KNolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Physician a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASES day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IZURE YEARS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy page perform certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation Hospital or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Yeartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLNEY MO 18101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 **Physician** Month 19, Margaret Virginia Wisner July 8:19 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center For Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Voor 1 M & F 220-07-4298 87 11/27/1919 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2XNo Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Grove Manor Drive, Apartment 418 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be William Henry Dieteman Harriett Rebecca Benser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Hitchens Avenue, Ocean City, Maryland 21842 Sharon Dee Robertson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc 07/20/2007 Baltimore, Maryland 21. Signaturo el Emeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pomeneutre morth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💓 Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPICE ٩ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide \*\*Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chances ST POWEN MO 2204 31. Date filed (Month, Day, Year) HARVES N.

Registrar DHMH 17 Rev 1/2001

State

wo 32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** obert /Medical 4a. Facility Name (If not institution, g 4b. City, Town, or Location of Death County of Death Examiner Randallstown Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Davs Hours Min. Director 212-30-6400 1/1/1935 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Carroll Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1575 Marriottsville Road 21104 S. A. Funeral U. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify Ş Q 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Lineman Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Robert Grav Whippo Grace Edna Bittner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald Eugene Whippo (Brother) 19425 Dickerson Hollow Road Flintstone, Mary 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 7/23 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bayview Crematory 2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Es ichail Essex, Maryland 21221 Part1. Enter the disease, I comprofile in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Approximate Interval Between iset and Death Immediate Cause (Final neve Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) ohysician use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. | 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 1□ Yes 21 NO or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 30 No Other: 2 ☐ ER/Outpatient 3 ☐ OOA 2 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number

441

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avace

32. Registrar's Signature

onin

Year)

31. Date filed (Month, Day

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Elworth Wiggett 2007 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CAMPUS ALLEGAN Birthplace (Steat Country) Mass. 8. Date of Birth Aug. 10 1915 5. Social Security Number Age (In yrs. last birthday) (State or Foreign **Funeral** Days Hours Min. Months 1X M 2□ F 91 213-07-5483 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 10a State 10b. County MD Flintstone 1 ☐ Yes 2 No Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13434 Scofield Road N.E. 21530 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify White by 3€CMVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Refrigeration Owner is 1 and 2 should be filed wo of Health and Mental Hygier item 27 Is marked other the other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie Mabel Beach Roy G. Wiggett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra once. Barbara Listman /daughter 13434 Scofrield Road N.E.Flintstone MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State St. Jon fier Cath, Church 7/20/07 Hydes 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service. 22. Name and Address of Facility 300 Mace Ave. Balto. MD 48 Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Pair 1. Enter the disease, or complications, or heart failure. List only or ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 days /Medical Due to (or as a consequence of): Atrial Fibrillation unknown Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown ICA stenosis Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ Certification:

Examiner attending physician and for use as the burial-tran certificate be ned by the a P.O. signed t or Vital Records, certificate Division

with

filed within 72 hours after death

Hygiene.

Pages 1

Baltimore, Maryland 21215-0036

e Hospital or Attending Phys 24 hours after death.
e Funeral Director: After this letely filled in by the funeral di After this completely filled in by within 24 hours

To the Funeral

Medical

State Registrar

28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and title

29c. License number

D0066101

29d. Date signed (Month, Day, Year)

July 17, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

900 Seton Drive Cumberland, Md 21502

Cheema Abdol 31. Date filed (Month

Registrar's Signature

Earl Thomas Willia	ıms		State	of Maryland	/ Depar	tment of	Health an	d Mental	Hygiene	0.0	17 0960
	R	For State			Certi	ificate of	Death		2. Date of Dear	eg. No.	3. Time of Death
Physician/ Medical Examine	-		e (First, Middle,Last homas W		Jr.				Month July 16, 2	Day Year	0020 hrs
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Funeral Director	1	216 <b>-</b> 19	7010	M 2 F	26		Months Day		/lin.	For	eign Country) MD
	Ţ	Jsual Residence o	f Decedent							-1-76.01	10d. Inside City Limits
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uh the Maryland 23a or 28a-f show notified at once.		2713 Gv	ynns Fa	lls Par	k			21216		USA	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mantal Hygens are 77 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Bo Completed by Filmoral Director	E	11. Marital Status	ied 2 V Married	12. Was Decede		3. 13. Wa	as Decedent of H es, specify Cuba	lispanic Origin? an, Mexican, Pue	( Specify Yes or No erto Rican, etc.)	14. Race - An White, etc	nerican Indian, Black,
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b 21215-0036 should be filed within 72 hours after and Meral Hygiens ris marked other than "natural", natic event, the Medical Examiner.	<u> </u>		th (First, Middle, Last)					18.Mother's Na		Maiden Surname)	
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21 hould thend Mer is mar			lame/Relationship (T		. 1		-			mber, City or Town, S	
ore, MD ss I and 2 sho of Health and If item 27 is her traumati	-	Jacque l 20a. Method of Di	tta Will	iams/Mo	ther 20b.P	2 / 1 lace of Dispo	Sition (Name of c	ns ral	25 Park	20c. Location - City	MD 21216
S 1 S I			X-cremation 3		State MC	tro C	remate	ry /	<del>/18/</del> 07	Balto.	MD
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr	ŀ	21. Signature of F	Other Specify uneral Service Licer	nsee		227	Name and Addre	ss of Facility F			ral Home
		M4/	fl force	clientions that cour	end the death	<del>- 19.2</del>	00 I.ib	erty R	d. Ran	rest, shock, or heart	Approximate Interval
Physician ∜Medical		f≠ıl √e. List o	nly one cause on e	ach line. Multiple Guns			the mode of ayin	9,000	,		Between Onset and Death
xaminer		Imperiate Cause or condition result		Due to (or as a co							
	إي	Sequentially list of if any, leading to		Due to (or as a co	nsequence of	):					<del> </del>
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e executed cian and rial - transit	dical	UNPENDE		AMENDED	20 a-c,	22 pe	er fh g8	69 7-24	-0/ vt		
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	₽t	IF FEMALE: 23b. Was deceder	nt pregnant in the	23c. If yes, out			etal death	3 Ectopic pr	egnancy	23d. Date of del Month	ivery Day Year
× 68 h certif tending use as	iciar	past 12 mont	hs?	4 Pregnan	t at time of dea		other (Specify)				
Box he death c the atten hed for us	Physi	1 Yes 2	No 9 Unknow	a Olikilowi		esulting in the	underlying caus	e given in Part I	. 23e. Did	tobacco use contribut	te to the cause of death?
ries that the signed by I be detach	습	Part II. Other sig	Inicant conditions	contributing to a	cadi but not re	Southing in and	and onlying care			es 2 🗸 No 3	Probably 4 Unknown
ords, w require s been si should b	eted								24a. Wa		re autopsy findings available r to completion of cause of
Records, The law require ficate has been si, page 2 should b	Completed			· · · · · · · · · · · · · · · · · · ·						form <u>ed</u> ? dea	th? Yes 2 No
Vital Rec	انه	25. Was case ref						Other			
of Vital ng Physician: After this certi:		1 Yes  27. Manner of De	2 No	Hospital: 1 Inp	atient 2 🗸	ER/Outpatie		njury at Work?	lursing Home 5 28d. Describ	Residence 6 0	Other:
on of on of on oding Ph. th After the funeral	<u>:</u>	1 Natural	5 Pending	Jul 15, 20	ay Year) 07	2346 hrs	′′′	Yes 2 🗸 No	Subject sh	not	
Division tal or Attendir rs after death. al Director: A led in by the fu	ficat	2 Accident 3 Suicide	Investiga 6 Could no	28e Place	of Injury - At h	ome, farm, str	eet, factory, offic	e building, etc.	28f. Location	(Street and Number	or Rural Route Number, City
Div Hospital of 24 hours all Funeral Distely filled	Certification:	4 V Homicide		(-)	Street					, State) Lane, Baltimore, M	A 404/4
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)	Certifying Physi  Medical Examin	er:On the basis of	examination a	ge, death occ ind/or investig	urred at the time jation, in my opin	, date and place ion, death occul	red at the time, da	iuse(s) and manner as te and place, and due	to the cause(s)
To the within 2 To the complete	Medical	29b. Signature ar		and manner sta	ted.			ense number			(Month, Day, Year)
		Par	. ()	- P	alle	l .s	О.	C.M.E.		July 16, 2007	7 
10			dress of person who				111 Penn	Street Balti	more, MD 212	201	
Sta	ate.		ronica-Pollak M	32 Reg	nt Medical l istrar's Signati		1111 01111	5 <b>5</b>			
Registr			UL 2 4 20	107 189.00	me St	400	di)				
DHMH 17 Rev 1/20	01	-		DOME		ORIGIN	AL				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Margaret Ann Wolfkill July 21 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Futurecare Cherrywood Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M **XX**F Days 90 Yrs Director 212-38-0232 Feb. 16, 1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. the Martinal Experiment 10c. City, Town or Location 10b. County Director Maryland Baltimore Reisterstown 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21136 6227 Deer Park Road Funeral America . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes XX No Baltimore, Maryland 21215-0036 Specify: White ģ 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Laundry Worker Rosewood Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Vaughn Bertha Bailey ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne W. Joy (Daughter) 6227 Deer Park Road; Reisterstown, Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) July 24, 20a. Method of Disposition 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Evergreen Mem'1 Gardens Finksburg, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road; Owings Mills, MD 21117 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mass /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as I IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 | Yes 2 | No 3 | Probably 4 | Unknown ennu Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy performed this certificate 2 No or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 1 ☐ Yes 2 ER/Outpatient 3 DOA ဥ funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural Division 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate onset and Death

Year

Day

29d. Date signed (Month, Day, Year)

1XXYes 2 □ No

Maryland

10:05 A.M

Registrar DHMH 17 Rev 1/2001 4 Homicide

(Check only one)

30. Name and add

31. Date filed (Month, Day,

Year)

2007

JUL 2 4

29b. Signature and title of certifier

MO

person who completed cause of death (Item 23a) (Type, Print)

emun

29a. Certifier

Medical

State

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

838

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #4c, perMD, 0870, 8/23/07 ITCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 200<sup>Year</sup> **Physician** 17 July Robert Leroy Waters 9:05 /Medical St. Mary S 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner County Charlotte Hall Veterans Home Charlotte Hall 8. Date of Birth (Month, Day, Year) 1918 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1⊠M 2□F 89 Director April 578-12-7788 29 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show at a or 28a-f sho t be notified a 1 XYes 2 No MD Prince George Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8108 Poplar Hill Dr 20735 U.S.A. items 23a "natural", or items 23a within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Black \$ 3 ☑ Widowed 4 □ Divorced Year or Dates Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Chemical Warfare Tech 9th Military permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If Item 27 is marked other 1 any Injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Braxton Irene Green 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8108 Poplar Hill Dr Clinton Md 20735 Monica Jeffries Baltimore, 20b. Place of Disposition (Name of Cemetery, crematory or other place)

Cheltenham Cemetery 7-26-07 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McLaughlin Funeral Home hrylle 2019 MLK Jr AVe, SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Box 68760, attending physician pe Physician/Medical the use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 certificate pidemia 2 No 1∐ Yes Division or Vital | 25. Was case referred to medio 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af completely filled in by the full 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2007 5:45 A R. July 18. Joseph Whaley 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1፟M 2□F 1946 61 Michigan 364-46-9871 April 6, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 11346 Amberlea Farm Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

**Physician** /Medical **Examiner** 

1 - For State Registrar

10a State

**Physician** 

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural",

al Hygiene.

the Medical

Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i once.

Director

Funeral

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

burial-tran the signed by t page 2 ours after death. within 24 hours a

To the Funeral I

completely filled

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	No المَّلِدِ2	Specify:			Specify: V	Vhite		
eted	15. Decedent's Ed (Specify only highest gra	ducation (de completed)	16a.	Decedent's Us (Give kind of v	ual Occup vork done	oation during most of wo d)	rking	16b.	Kind of Business	/Industry		
To Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)			use retire CCCT				Law			
Ö	17. Father's Name (First, Middle, Last)					18. Mother's Nar	me (First, Middl	e, Maide		-		
0	Randall Whaley					Miriam	Weckes	ser				
	19a. Informant's Name/Relationship (7		19b.	Mailing Addre	ss <i>(Street</i>	and Number or R	ural Route Num	ber, City	or Town, State,	Zip Code)		
	David M. Whaley/					a Farm D						
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	meter	Disposition (A y, crematory o ery Crem	r other pla		Date Ly 22, 007		Location - City or :hesda, ]	Town, State Maryland		
	21. Signature of Funeral Service Licentification	gee MO117:	3	Robert 300 W.	A. Pu	ess of Facility Imphrey Fun Comery Aver	eral Hom	e, Ro	ockville,	Inc.		
	23a. Part1. Enter the disease, or compands, or heart failure. List only immediate Cause (Final	plications that caused the death. one cause or each line.					c or respiratory	arrest,		Approximate Interval Between Onset and Death		
	disease or condition resulting in death)	Due to (or as a conseque			r n K	277070				MINUTES		
-	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying	b. METASTATI Due to (or as a conseque	c	CANCE	R (	NKNOW.	N PRI	MAR	24	MONTHS		
mine	cause. Enter Underlying Cause (Disease or injury that initiated events	-	5,100 0	.,,								
al Exa	resulting in death) Last	Due to (or as a consequent	ence o	of):								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death	3 ☐Ectopic 5 ☐ Other		у	×.		23d. Date of de Month	elivery Day Year		
된		contributing to death but not resul	ting in	the underlying	cause giv	ven in Part I.	23e. Dio	tobacc	L o use contribute t	to the cause of death?		
ed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to 1  1   Yes 2   No 3   Pro											
omplete	24a. Was an autopsy performed? 1											
Ö	25. Was case referred to medical					26. Place of De	1  Yes ath (Check only		10 1210	s 2□No		
<u> </u>	examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☑	R/Ou	tpatient 3□	DOA Oth	ner: 4 🗆 Nursing I	Home 5□Re	sidence	6 □Other (Spe	ecify)		
Hospital: 1   Inpatient   2   And Inpatient   2   And Inpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Special Normal												
2 Accident 3 Suicide 4 Homicide  Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rule City or Town, State)												
29a. Certifier (Check only one)  1 **Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 **Index only one of the cause of												
Me										nth, Day, Year)		
	> Um S		( G		J	59929	]	Ji	14 18	2007		
	30. Name and address of person who		23a) (	Type, Print) MEDICA	L CE	NTER DRI	VE RO	CKV	ILLE MA	RYLAND		

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 200 unior /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Saltimore Var 1 Year | If Under 24 Hrs. ST. Hane: 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 30, 1939 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10 M 2□F 249-66-368 ± Usual Residence of Decedent South Carolina Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Funeral Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 PYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Blac Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vor Kers Comp. Unit Lol Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Wite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph L. Ru 2222 W. North 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart trillure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE STROKE Approximate Interval Between Onset and Death Physician DAYS /Medical Due to (or as a consequence of): Examiner FEBRELLATER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner due to (or as a consequence of) ARDIDMYOPATHY burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria BENJAMIN IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown NATSOR, 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 10 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number P21227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADIREDOL HOSPLIAL SRIDHAR St AGNEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month 2007 9:24 aM DORIS ANTIRI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) OK 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year Mar 30, 19 7. Age (In vrs. last birthday **Funeral** Days Months Hours 1945 290-40-8850 Director 62 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Marylan 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2X □No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 USA 8601 Manchester Rd. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced **Black** natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Registered Nurse Dept of VA 4yrs 7 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be Elnora Champion ပ Roy L. Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $8601\,$  Manchester Rd.  $\#401\,$  Silver Spring, MD.  $20901\,$ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. Crystal Antiri/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7-11-07 Alexandria, Va. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Tachycardia /Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection, Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a gonsequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Multiple Sclerosis Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperlipidemia 1 Tyes 2

No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy 2⊠ No 1⊟ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 RER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/9/2007

31. Date filed (Month, Day, Year) State JUL 1 1 2007 Registrar

William J. Crittenden 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D0054547

7350 VanDusen Rd Suite 350 Laurel, Md. 20707

			- For	eartment of Health and Mental Hygiene 2007 23697
		ÇΙ	Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physicia /Medic	_	Charlene Will Blue	July 8 2007 10:42 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			BALTIHORE WASHINGTON HEDICAL CENTER	
Ь	Funeral Director	5	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   New York   Months   Days   Hours   Min.   Feb 27, 1935   New York
	pur M		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation 10d. Inside City Limits
	Maryla f sho led at	ō	Moryland Caroline Presto	1 _ Yes 2 No
	r 28a-	irect	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	th witl 23a o Ist be	alD	5223 Bethleham Koad	21655 United States of america
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes 2▼No Specify:  14. Race - American Indian, Black, White, etc.  Specify: Black
5-0036	72 hor	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	edent's Usual Occupation 16b. Kind of Business/Industry
2121	within lene. than "I	mple	Elementary/Secondary (0-12) College (1-4or 5+)	be kind of work done during most of working DO NOT use retired)  Beautician  Beautician
	Hygiel Hygiel ther ther ther	S	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Maryland	d be f ental I ked of c eve	To Be	Gus Ellis	Elzora Barnes Ellis
ary	2 should be and Menta Is marked aumatic ev	F	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
_	and 2 salth a 27 is er tra	13	Michael Blue / Son 500	
Baltimore,	0 0		20a. Method of Disposition 1 Method of Disposition 20b. Place of Discemetery, completely,	ematory or other place)
ţ	nit. Pages partment of l ortant: If It Injury or o		4 □ Donation 5 □ Other (Specify)	r Cemetery July 14, 2007 Preston MD
Ba	permit. Pag Department Important: I any Injury o		21. Signature of Juheral Service Licensee  Warne & Mow6	Henry Funeral Home 510 Washington S Henry Funeral Home 510 Washington S Cambridge, MO 21613
	1000		23a. Part1. Effer the disease, or complications that caused the death. Do not e shock, a heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
VI.	Physician		Immediate Cause (Final disease or condition	se Arry Munia Onset and Death
1	/Medical Examiner		Due to (or as a consequence of):	0
	LAdillinei	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	nsit	Examine	Cause (Disease or injury	
Ć.	cate be executed physician and the burial-transit	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):	
8760	te be ysicia ne bur	dical	d	
9	ntifica ng ph as th	Med	IF FEMALE:	
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant    1	□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Year
	s that ned b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ıd	w requires that s been signed k should be deta		Regartention	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown
or Vital Records,	has bei	Completed	Didstes mellitro	24a. Was an autopsy findings available prior to completion of cause of
E E		Som	Morbid oberity	performed? death? 1
Vita	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Check only one)
or	is sing	. To	1 ☐ Yes 2 ☐ No	4 Nursing Home 5 Residence 6 Dotter (Specify)
on	tending Pt eath. tor: After th the funeral	tion	1 Matural 5 Pending (Month, Day Year) Injur 2 Accident investigation	
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ö	pital or ours afte eral Dir filled in	Cen		ath occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the complete	2	29b. Signature and title of certifier  MOELOWY_MARKET	29c. License number 29d. Date signed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )  D - 4 0 5 21  Full 8, 2 00 7
	1/2		30. Name and address of person who completed cause of death (Item 23a) (Typ	D-40521 July 8, 2007 e. Print) 325 HOSPITAL DRIVE STATE 208
	Ma	1	DR OCHANEY	gren BURNE, MD 21061
	Sta		31. Date filed (Month, Day, Year)  32. Pegistrar's Signature	
	Registi		JUL 1 1 2007 Brown &	ford

			1 - For State Registrar		State o	f Maryla	nd / Dep <i>Ce</i>	artment rtificate			and M		giene	007	236	93
	Dhusia	:	1. Decedent's Name (F	irst, Middle, Las	t)							2. Date of De		Year	3. Time of	Death
	Physic /Medi		GEOR	GE	L.		BABE	3				JULY	7	2007	213	32 M
	Exami	ner	4a. Fecility Name (If no	t institution, give	street and nur	mber)		4b. City,	Town, or	Location o	f Death			unty of Death		
			ATLANTI  5. Social Security Numb				s. last birthday	If Under		LIN	24 Hrs	0.0-4(.0)		WORCES		
	Funeral Director		429-46-852	41	<b>Ã</b> M 2□F		6 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da OCT • 12	y, Year) 2, 1930	O Birth	olace (State o ntry) ISSOUR	r Foreign I
	Pu ,		Usual Residence of De													
	anyla •hov	٦	10a. State 10 MARYLAND	b. County WORCES	emed	10c. 0	City, Town or Lo	LIN						1	0d. Inside Ci 1 ☐ Yes	-
	death with the Maryland me 23a or 28a-f ehow Frival be notified at	Funeral Director	10e. Street and Number		DIEK		DEF	10f. Zip	Code			1	10a Citizan	-41415-4-6		
	3a or	2	10316 CA		AD.			101. Zip		811			iog. Citizen	of What Cour	ntry?	
	death me 2	Jera	11. Marital Status	IIIEDD K	12. Was Dece	edent Ever in	U.S. 13.	Was Deced			gin? (Sp	ecify Yes or No Rican, etc.)	- 14.1	Race - Americ		
36	spes 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hyglene. If Item 27 is marked other than "netural", or Iteme 23a or 28a-f ehov or other traumatic event, the Medical Examinar must be notified at	by Fur	1 Never Married	_	Amed Fo	2 🗆 No		lfYes,spec 1 □ Yes 2		Specify:	, Puerto	Rican, etc.)		Black, White, ec <i>ity</i> : 7,	etc. VHITE	
9	2 hou	ted !	15.	Decedent's Edi	ucation	ales. 1901		dent's Usua	I Occupa	tion			16b Kind o	f Business/In-		
215	within 7; ene. then "ne	Completed	(Specify of Elementary/Secondary	only highest grad	de completed) College (1	-4or 5+)	(Give	kind of wor DO NOT us	k done d	urina most	of work	ng	100.11110		adatty	
21	ed wit	io O	8	,, (0 .2)		101 017		SALES	MAN				AUT	O PART	S	
Maryland 21215-0036	d 2 should be filed within in and Mental Hygiene. 7 Is marked other than "r	Be	17. Father's Name (Firs	t, Middle, Last)		BABB	SR.			18. Mother		e (First, Middle, 7.	<i>Maiden S</i> un ELMA	name) HIC	KEV	
Z.	shoul nd Me mark mark	ပ	19a. Informant's Name			DIIDD		na Address	(Street a			al Route Numbe				
	alth a alth a 27 le		PAULINE E.	BABB/W	IFE							RLIN, M				
ore,	of He of Herr		20a. Method of Disposit		Dam ( 4 )		Place of Dispo	sition (Nam	e of her place	)		Date	20c. Locatio	on - City or To	wn, State	
Ĕ	Pages ment of ent: If It ury or o		1 🕅 Burial 2 🗌 Cr 4 🔲 Donation 5 🗀				DALE CE				/11	/07	WHAL	EYVILL	E, MAR	YLAN!
Baltimore,	permit. Pages 1 and 2: Depertment of Health ar Importent: If Item 27 is any Injury or other treu <u>once.</u>		21. Signature of Funera	al Service Licens	0//	10134		Name and				ME, SEL	BYVILL	E, DE.	19975	j
			23a. Part1. Enter the di shock, or heart fai	isease, or comp	carlons that c	aused the dea	ath. Do not ent	er the mode	of dying	, such as o	cardiac c	or respiratory ar	rest,		Approximate Interval Bety	9
V.	Physician		Immediate Cause (Fina disease or condition		CVA									4	Onset and D	
1	/Medical Examiner		resulting in death)		Due to (	or as a conse	equence of):									
		_	Sequentially list condition	ons,	b. Due to /	or as a conse	augnos of):									
	uted I	uln e	if any, leading to immediate. Enter Underlyin Cause (Disease or injur	9	D00 t0 (	or as a conse	querice or).									
Ć.	execu in and ial-tra	Examiner	that initiated events resulting in death) Last		c. Due to (	or as a conse	quence of):									
8760,	cate be executed physician and the burial-transit	dical			d											
9	ntifica ng ph	Med	IF FEMALE:													
Box	death certific attending p	lan/I	23b. Was decedent pre- in the past 12 mon	griani		rth 2 Fet	al death 3	Ectopic pre	gnancy				100	Date of delive	•	<b></b>
0	The law requires that the death certific lie has been signed by the attending is age 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregna 9∐Unkno	ant at time of wn	death 5	Other (spe	icify)					Month	Day Y	/ear
Δ.	res that I igned by be deta		Part II. Other significan	t conditions co	ntributing to de	ath but not re	sulting in the u	nderlying ca	use givei	n in Part I.		23a. Did to	bacco use c	ontribute to th	e cause of de	eath?
Vital Records,	w requires been sign should be	ed by										101	es 2 No	3 Prob	abiy 4 □U	Inknown
ဝင္ပ	law re as bee 2 sho	Completed										24a. Was		b. Were autop	osy findings a	available
Ä	The I	E		<u>-</u>								autop perfor	sy /	prior to con death?	npletion of ca 2 No	use of
/ita	Physician: Th this cartificate al director, pag	Be (	25. Was case referred to examiner?				,			26. Place	of Death	(Check only o		7	20110	
of\	Physic this c	၉	1 Yes 2 No				ER/Outpatien			4 🗀 1401:		ne 5 Resid			')	
n C	ling After une	lo lo		Pending	28a. Date o (Monti	f Injury r, Day Year)	28b. Time of Injury		Work			8d. Describe h	ow injury occ	curred		
Division	deatl deatl ctor: / the	flcat		investigation  Could not be	28e Place	of Injury - At I	nome, farm, str	M factory		es 2□N		8f. Location (S	treet and Nu	mbos as Rusa	/ Pouto Numb	ha
Ö	al or At s efter of I Dirac of in by	Certification;	4 🗌 Homicide	determined	buildin	g, etc. (Spec	ify)	oot, factory,	Onice		·	City or Ton	n, State)	mber or nura	HOUSE NUME	767,
	Mospital or 124 hours efter Funerel Diracilletely filled in E	Medical C	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exami	sician: To the ner: On the ba and mann	sis of examin	owledge, death ation and/or inv	occurred a restigation, i	t the time	, date and nion, death	place, a	and due to the ded at the time, d	ause(s) and date and plac	manner as st.	ated. the cause(s)	)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title	of certifier				29c.	License	number			29d. Date sig	ned (Month, L	Day, Year)	
	N		> (M	1				D	536	12			7/7	107		
1	N.V		30. Name and address of	of person who co	ompleted cause	of death (Ite	m 23a) (Type,	Print)					. 1 .	,		
V	) //		Andrea	- V 1 a	lier 1	ND "	9733	Heali	hw	aux	Dr.	Berlin	i M	D 218	11	
	Sta Registr		31. Date filed (Month, Da	ay, Year) IL 1 0 21	- 49	mistrar's Sign	ature	Para		0			7			
	, riegisti	- 1	30	'L	UUI Z	Market 1	11 11	000001								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ju 0615 M Barrett 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisburg Retroba Nursing Ctr.

5. Social Security Number 6. Sex 7. Age (Im)ris. last birthday) Wicomico Dalisburg If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 222-09-9128 91 Director De<u>laware</u> 4-16-1916 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Worcester Ocean Pines 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1004 Baybreeze Lane 21811 Funeral USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify. ģ 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>1</u>2 lineworker Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Tibbitt Eva Lore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Niblett - daughter 1004 Baybreeze Lane, Ocean Pines, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 7-10-07 Delmar, Delaware 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or companies shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) o and /Medical Due to as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? 1☐ Yes 2 ☐ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22/10 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ۵ this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Afer 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: n by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Ave. Salisbury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hobins, M.D. 200

32. Registrar's Signature

H:

1 0 2007

William 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician BRAXTON 11: 45 A.M MARIANNE C. 06-2007 07-/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SALISBUR WICOMICO HOSPICE THE LAKE COASTA L If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2X F 192-38-1484 60 Director 4/2/1947 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 TXNo Director Maryland Wicomico Salisbury 10e. Street and Number 10g, Citizen of What Country? 10f Zin Code 1408 Meadow Point Court 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No <u>م</u> Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Covaleskie Anna J. Kilfeather 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Braxton/son 9163 Drawbridge Dr., Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/11/07 Resurrection Cemetery Bensalem, PA 21. Signature of Funeral Service Licensee Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Parl 1. Enter the seas , or complications that seem of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OF BHADARIL WITH LIVER MRTASTAS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No 9 □ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performe Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Depatient Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director; filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coastal Hospice at the Lake, PO Box 1733, Salisbury, MD 21801 Dr. G Waris

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 1 0

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,	Baltimore, Maryland 21215-0036
the Hospital or Attending Physician: The law requires that the death certificate be executed	permit. Pages 1 and 2 should be filed within 72 hours after death with the I
in 24 hours after death.	Department of Health and Mental Hygiene.
the Funeral Director: After this certificate has been signed by the attending physician and	Important: If Item 27 Is marked other than "natural", or items 23a or 28a-
pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit unit	any Injury or other traumatic event, the Medical Examiner must be notifi

۲		For State Registrar	State of Ma	aryland		irtment of F tificate of i				gienę 📗 Reg. No.		20/01
Physic	ian	1. Decedent's Name (First, Middle, Nancy Richards	•	r					2. Date of Dea	ath Day 1	Year	3. Time of Death 3:55% m
/Medi Exami		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o		of Death	,,,	4c. County		
		Anne Arundel Me 5. Social Security Number		<b>r</b> e (In yrs. la:	st birthdav)	Annapo If Under 1 Year	lis   If Under	24 Hrs.	8. Date of Birt	h	9. Birtho	place (State or Foreign
Funeral Director		225-50-8075	1□M 2 <b>X</b> F	68		Months Days	Hours	Min.	7/6/19	938"	$\overset{Cour}{\mathbf{I}}$	exas
/land ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
ne Mar 8a-f sh otified	Director		Arundel	Ar	nold	1.4						1 □Yes 21X No
th with the 23a or 2 ist be no	al Dire	10e. Street and Number 488 Bay Green	Ct.			10f. Zip Code	210	012		10g. Citizen of V USA		ntry?
DEMILITIOTE, INTERTIGINE Z I Z I 35-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? ed 1 Tyes 2 N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2124No	lispanic Or an, Mexica Specify:		cify Yes or No- lican, etc.)	. 14. Raci Blac Specify	k, White,	an Indian, etc. hite
vithin 72 hounder.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	S Education t grade completed)  College (1-4or 5	+)	(Give life. E	lent's Usual Occup kind of work done OO NOT use retired	during mos d)	st of workin	g	16b. Kind of Bu		
id be filed v lental Hygie ked other t ilc event, th	To Be Co	17. Father's Name (First, Middle, L John Robert Ric	Last)		500	cial Work	18. Moth	er's Name re Mel		Maiden Surnam		vices
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ages 1 and of the mt of the mt of the mt of the mt of the mt or other or other mt or other		20a. Method of Disposition  XI Burial 2 ☐ Cremation		cei	metery, cren	sition (Name of natory or other place	- 1		ate	20c. Location -	•	
Dallinor permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service)		меаа	22	ge Cemete  . Name and Addre	ss of Facili	7/9/20 ityHardo	esty Fu	Elkridg neral H	lome,	
O 88 E 5 8		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death.		2 Ridgely			-		·01	Approximate
Physician	ı	Immediate Cause (Final disease or condition		ie. Eu m	4							Onset and Death
/Medical Examiner	ı	resulting in death)	Due o (or as	a conseque	ence of):							-
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):							
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The color day, F.O. BOX 00/00,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3□	Ectopic pregnanc Other (specify)	y				te of deliventh	ery Day Year
law requires that as been signed to 2 should be deta	b	Part II. Other significant condition	. 4	ut not result	ting in the ur	nderlying cause giv	ren in Part	I.	23e. Did to			he cause of death?
The law returned that has bee	Completed	Sec	onday	10	5 ap	tic 5	hoc	K	24a. Was autor perfo	osy rmed?	prior to co death?	opsy findings available impletion of cause of 2 ☐ No
VILA ilclan: certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:			. all post Oth	or.		(Check only o	nne)		
SION OF tending Phys leath. tor: After this the funeral dir	ion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investig	28a. Date of Inju (Month, Da)	ry 2	R/Outpatien 28b. Time of Injury	28c. Inju	4 ⊔ N	2		dence 6 Oth	-	fy)
or Atten after deat Director:	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 290 Place of init	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office			8f. Location (S City or Tox	Street and Numb vn, State)	er or Run	al Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C		g Physician: To the best of Examiner: On the basis of and manner sta	f examination								
(	Ž	29b. Signature and title of certifier	6			29c. Licens				29d. Date signe		Day, Year)
(10		30. Name and address of person	who completed cause of d	eath (Item	23a) (Type,			804		-		
S	ate	31. Date filed (Month, Day, Year)	Peter. 32. Registr	s Signatu	ire	A.	Th	10	/t no	ropeli	5 /	1102144
Regist		1111	0 5 2007	San and a second	. K	Level	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1,2007 **Physician** JMTŸ 0855 Virginia Brockett /Medical 4a. Facility Name (If not institution, give street and number) 8707 Crest Road 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min. 1 ☐ M 2 💢 F 7/14/1930 212-28-4338 76 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD 1 ☐ Yes 2 X No Anne Arundel Severn Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8707 Crest Road 21144 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. Specify: <u>\$</u> 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Bus Company

8703 Crest Rd.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

18. Mother's Name (First, Middle, Maiden Surname)

22. Name and Address of Facility Hardesty Funeral Home PGA. 851 Annapolis Road

20c. Location - City or Town, State

Baltimore, MD

29d. Date signed (Month, Day, Year)

Lavinia Ahurst

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Severn, MD 21144

Date

7/6/2007

**Physician** /Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 12 any injury or other traumatic event.

Be

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17. Father's Name (First, Middle, Last)

Stephen Brockett

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

1 ☐ Burial 2X Cremation 3 ☐ Removal from State

(Son)

George Roth

20a. Method of Disposition

**Examiner** 

the burial-tran

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner Completed by Be ( Certification: To

Medical

29b. Signature and title

31. Date filed (Month, Day, Year)

23a. Part1. Enter the disease, or com shock, or heart failure. List only			Approximate Interval Between
Immediate Cause (Final disease or condition	. GLIOBLASTOMA Multi	forme	Onset and Death
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Due to (or as a consequence of):		
resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown	23d. Date of deliv	rery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 ☐ Yes 2 ♠ No 3 ☐ Pro	
		24a. Was an autopsy performed? death?  1 Yes 2 No 1 Yes	opsy findings available ompletion of cause of
25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Pasidence 6 □Other (Spec	ffy)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury at Work?  M   1 □ Yes 2 □ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rui City or Town, State)	al Route Number,
	ysician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occu and manner stated.		

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

ASAMON

State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Ess

29c. License number

D0058779

305 Hospital drive Glen Burnie MD

red Bennett		State of Maryland / Department of Health and Mental H			
		1- For State Certificate of Death		W. 100 - 10	17 2370
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2 Date of Deat	eg. No. th	3. Time of Death
ledical Exami		Fred Warren Bennett	Month July 1, 200	Day Year 07	1110 hrs
. ~		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	h	THE COUNTY OF BEE	
		Baltimore Washington Medical Center Glen Burnie  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	Date of Bir	Anne Arunde	
Funeral Director		Months Days Hours Mir	,	Fore	eign
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any .		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryland 28a-f show any Lat once.	5	Maryland Anne Arundel Gambrills			1 XX Yes 2 No
th the Maryland 13a or 28a-f sho 10tified at once.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	untry?
th the 23a or notifie		2605 Chapel Lake Drive #112 21054		USA	
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married Armed Forces? 13. Was Decedent of Hispanic Origin? ( S	Specify Yes or No o Rican, etc.)	White, etc.	erican Indian, Black,
ter de		1 Yes 2XX No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	nite
ours af	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Busines	s/Industry
6 172 hc	lete	Elementary/Secondary (0-12)  College (1-4 or 5+)  during most of working life. DO NOT use rel	tired)		
within giene.	Completed	5+ Attorney	75	Self-Empl	oyed
1215-0036 debe filed within 72 dental Hygiene. narked other than '	Be C		e (First, Middle, I a C Huq	Maiden Surname)	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	입	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or			te, Zip Code)
MD d 2 shc llth and n 27 is		Susan A. Bennett/Wife 2605 Chapel Lake Dri	ve, Gamb	rills, Mar	yland,21054
nore, MD 2 ages I and 2 shoul ent of Health and M nt: If item 27 is m		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  2 Cremation 3 Removal from State	Date	20c. Location - City	or Town, State
Pages nent o		Lakemont Memorial Gardens  4 Donation 5 Other Specifiy: Gardens	/07/2007	Davidsonv	ville, Md.
Baltimore, permit Pages I an Department of Her Important: If ite		21. Signature of Puner 13 Tvio Licensee 22. Name and Address of Facility			Funeral Home
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			and 20715 Approximate Interval
Physician Wedital		failure. List only one cause on each line.	or respiratory arr	est, shock, or fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  A Head and Chest Injuries  Due to (or as a consequence of):			Death
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	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
, is	Examiner	events resulting in death) Last Due to (or as a consequence of):			
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Box 68760, e death certificate be the attending physical of for use as the burn	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregr	ancy	23d. Date of deliver	ery Day Year
ox 6 eath cer attendi	sicis	4 Pregnant at time of death 5 Other (Specify)			
O.O. Be that the de ned by the detached fi	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
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ords,	Completed		24a. Was		autopsy findings available
e law e has e	dm			rmed? death'	
Vital Rec ysician: The l his certificate b		25. Was case referred to medical 26.Place of Death (Check	1 Yes	2 No 1 🗸	Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should 1.	To Be	examiner?	ing Home 5	Residence 6 Ott	ner:
n of ling Ph After t funeral	ايّا	27. Manner of Death  28a. Date of Injury  1 Natural 5 Deadles Jul (North Day, Year)  28b. Time of Injury 28c. Injury at Work?  1022 hrs 1 Yes 2 M No		how injury occurred auto collision	
ivision or Attendi after death. Director: I in by the f	atio	2 Accident Investigation			
jvisi I or At after d I Direct	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	or Town, S	State)	Rural Route Number, City
		29a. Certifier	1	Route 100 E, Pasac	
To the Hos within 24 h To the Fun completely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To vit Con	Mec	and manner stated.  29b. Signature and title of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)
(10)		Laurhe Jelef Um O.C.M.E.		July 2, 2007	
(IO)		30. Name and address of person who completed cause of death (Item 23a)		.1	
-		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	ID 21201		
St	ate	31. Date filed (Month, Day, Year) 2007 32. Cegistrar's Signature			

ORIGINAL

			For	State of Ma		Depa	artment	of H	ealth a		_		_	7	23704
			State Registrar			Cei	rtificate	e or L	Jeatn		2. Date of	Reg. Ne	Ö.		3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Las.	, L	BEN	151					Month	O Y		Year	0 3 6 0 M
	/Medic		4a. Facility Name (If not institution, give	street and number)	0240	8001		Town, or	Location o	f Death	0 (	`	c. County o		0,00
	Examin	er	Ginger Cove Heal		•		,,		nnapo				Anı	ne A	rundel
	Funeral				e (In yrs. last	birthday)	If Under Months		If Under 2		8. Date of (Month,	Birth			place (State or Foreign
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	and *	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	ocation							1	0d. Inside City Limits
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	28e-	Director	10e. Street and Number		L		10f. Zip	Code				10g. C	itizen of W	hat Cour	ntry?
	hin 72 hours after death with the Maryland a. "Insturel; or Items 23e or 28e-1 show Medical Examiner must be neitified at		5309 River Cresce	ent Drive					214	01			U	.S.A	•
	deat	by Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13.	Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or Rican, etc.)	No-		- Americ	ean Indian, etc.
92	or Ite	y Fu	1 Never Married 200 Married	1XXYes 2 □ N			1 ☐ Yes 2		Specify:				Specify:		
8	hours turel',		3 Widowed 4 Divorced  15. Decedent's Ed	If Yes, Give Year or Dates:		6a Dece	dent's Usua	I Occupa	tion			16b I	Kind of Bus	siness/In	dustry
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ylaı		2	Robert C. Beni								uise T				
Maryland 21215-0036	0 0 0		19a. Informant's Name/Relationship (7 Nanette Bennet/v								l Route Nui				yland 21401
	1 an Heal		20a. Method of Disposition	VII.G			sition (Nam				ate	-	ocation - 0		
nor	Pages nent of int: If its iry or o		1 Burial 2 Fremation 3 \( \) 4 Donation 5 Other (Specify	Removal from State			matory or of e Crei			7772	007	R:	1+im	ore	Maryland
Baltimore,		1	21. Signature of Faneral Service Licen	4	2				-						1 Home
ã	permit. Departr Imports eny inji	1/2	I tood E	Till	der										MD 21401
	-		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. I	Do not ent	ter the mode	e of dying	g, such as	cardiac c	r respirator	y arrest,			Approximate Interval Between
	Pnysician	8 1	Immediate Cause (Final disease or condition	acu	Mo	on 1	chi	on	i c	on	extra	i He	when	an	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequen		10	,		-			U		
	<u> </u>	<u>.</u>	Sequentially list conditions,	b. Due to (or as	a consequen	Ce on.	7 11							_	geen
	rted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00	u 001100qu011	0.7.									
Ć,	ie be executed ysician and e burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):									
190		cal		d											
89	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physiclan/Med	IF FEMALE:		-										
Вох	ath ce trend or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal de	ath 3[	□Ectopic pr						23d. Date Mon		ery Day Year
<u>o</u> .	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or deatr	1 5	Other (sp	өспу)				_			
<u>α</u>	that the by detact		Part II. Other significant conditions of	ontributing to death b	ut not resultin	ng in the u	ınderlying ca	ause give	en in Part I.		23e. D	id tobacco	use contr	ibute to t	he cause of death?
Vital Records,	quires n sign ald be	ed by									1	☐ Yes	2 X No	3 🗌 Prot	oably 4 Unknown
00	sw require s been si 2 should b	Completed									24a. W	tas an utopsy	24b. V	Vere auto	ppsy findings available
R	The lav	om									p	erformed?	d	eath?	2 No
ita	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?							of Death	(Check or	ly one)			
of V	S D	2	1 ☐ Yes 2 📉 No	Hospital:			-	_	NU	_	me 5□R				(5)
חכ	ding Fune	lon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da)		b. Time o	M Z	8c. Injury Work	rat ⟨? Yes 2 🔲		28d. Descri	be now inj	ury occurre	90	
Division	or Attending after death. Director: After in by the fune	fical	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home	, farm, st			overeller i	-				er or Run	al Route Number,
Ö	al or / s after if Dire	Certification:	4 Homicide	building, et	c. (Specify)					Į	City or	Town, Sta	te)		
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowle	dge, deat	th occurred Nestigation	at the tim	ne, date an	d place,	and due to	the cause(	s) and mai	nner as s	stated. o the cause(s)
	the H nin 24 the F nplete	Medi	one)	and manner sta	ated.	1.5	40		number						Day, Year)
<b>.</b>	70 TO 70	_			al Of	fice	r   250					250.2	h. C	4	3.003
7			Hospice of  30. Name and address of person who		•	Ba) (Type	Print)	ע 2	21438				m	7)	100/
	7+1 1+1	+	Michael J. LaP					Highv	vay,	Anna	polis.	, MD	21401		
	Sta		31. Date filed (Month, Day, Year)		rar's Signature		1	<i>.</i>							
	Regist	rar	JUL 0 6	LUU1	su ,	D.	good	U							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 7:49 PM **Physician** 2007 Stephen Jeffrey Brown, Sr. /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs. Maryland Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X**M 2□F Yrs. 1949 Pennsylvania Director 205-36-4983 Sept 18, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heath and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or; any injury or other traumatic event, the Medical Examiner must hem 21740 U.S.A. 11000 Coffman Ave Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I □Yes 2 No fYes, Give rear or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Manager Paint & Glass 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Gerald Brown Nancy Lee Batey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Jean Brown / wife 11000 Coffman Ave Hagerstown MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Other (Specify) Smithsburg Crematory 7/14/07 Smithsburg, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -Dhc /Medical onsequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit and Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Day lor Month Year in the past 12 months? 5 ☐ Other (specify) detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1∐ Yes 2 DN 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Lampatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. Manner of Death completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: Director: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide or A Hospital 24 hours Funeral ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier aous, ro

State Registrar

TIQU

DHMH 17 Rev 1/2001

Anticham Street

d cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner

Funeral Director

For	State of Ma	ryland / E	epartme	ent of H	lealth a	nd Me	ental Hy	giene	007	007	0 -
1 - State Registrar			Certifica	ate of l	Death		ı	Reg. No.	UII	201	UI
1. Decedent's Name (First, Middle, La	nst)						2. Date of Dea Month	ath Day	Year	3. Time of E	Death
EUGENE EDWARD	BAUMANN, S	SR.					July	6	2007	1319	ı. N
4a. Eacility Name (If not institution, give		0			Location of	Death	•	4c. (	County of Death		
PENINSULA KEGIONI					BURY	,		N	100ma		
	Sex 7. Age 1⊠M 2□F	(In yrs. last birt	Yrs. Month	der 1 Year is Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 9/20/1	y, Year)	9. Birth Cou Mary	place (State or Intry) Land	Foreig
Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	n or Location							10d. Inside City	/ Limit:
MD Worces	ster	Girdle								1 Tes	<b>≱</b> No
10e. Street and Number				Zip Code				10g. Citiz	en of What Cou	intry?	
5913 Taylor Landi	<del></del>			1829					USA		
11. Marital Status	12. Was Decedent E Armed Forces?		13. Was De	cedent of H pecify Cuba	ispanic Orig an, Mexican	jin? (Spec , Puerto P	cify Yes or No lican, etc.)	.   1	<ol><li>Race - Amer Black, White</li></ol>		
1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	0	1 ☐ Yes	2 <b>X</b> No	Specify:				Specify: W	hite	
15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's U (Give kind of life. DO NOT	work done	durina most	of workin	g	16b. Kin	d of Business/I	ndustry	
Elementary/Secondary (0-12)	College (1-4or 5+		aterma		7	_		s	eafood		
17. Father's Name (First, Middle, Las	t)				18. Mother	r's Name	(First, Middle,	Maiden 3	Surname)		
Lawrence Frederic	ck Baumann				Mary	Hild	la Cart	wrig	ht		
19a. Informant's Name/Relationship	(Type. Print)			,					Town, State, Z		
Frances Baumann	(wife)				nding		Girdle		MD 21 cation - City or 7		
20a. Method of Disposition		cemeter	Disposition (Pry, crematory of Chill Ceme	or other plac	- i	" 11/2			letree,		
21. Signature of Funeral Service Lice		- <u> </u>	22. Name	and Addre	ss of Facility	L Hon	ne, Prof	fessio	nal Assoc	ciation	
- Markerel	14 Dele	n	103 L	inden	Ave.	, Poc	comoke	City	, MD 21	851 Approximate	
23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	y one cause on each line	е.		lode of dyli	ly, such as	cardiac oi	теѕрнаюту а	nest,		Interval Betw Onset and D	veen
disease or condition resulting in death)	a.  Due to or as a		101116 of):	0	1				-		
Sequentially list conditions	b. Chronic	Obst	netive	- Kul	mona	ry	Diseas	e			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	ot):								
that initiated events resulting in death) Last	c. Orona Due to (or as a	Vy H	-teru	\	DISE	ase	•				
, cooling in dealin, 2001	Due to (or as a	H/C	S 4 0	cK							
	0.		3000								
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		3 □Ectopi	c pregnanc	v			2	3d. Date of deli	,	
in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at		5 Other		,				Month	Day Y	'ear
9 Unknown											
Part II. Other significant conditions	contributing to death bu	0	n the underlying					obacco u Yes 2[	se contribute to ] No _ 3		eath? Inknow
2,100		رحر					24a. Was	an	24b. Were au	topsy findings a	availabl
							auto		prior to death? 1 ☐ Yes	completion of ca	use of
25. Was case referred to medical examiner?	Luciant			Lou		of Death	(Check only	one)			
1 ☐ Yes 2 No	Hospital: 1 Inpatier		·	DOA Oth	4 🗆 🗓				Other (Spec	cify)	
27. Manner of Death  1. ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day		Time of Injury M	28c. Inju	ryat 1k? Yes 2 ∐i		8d. Describe	now injury	y occurred		
2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not 1 4 ☐ Homicide determined	be 200 Place of init	ry - At home, fa :. (Specify)		-	res Z		8f. Location ( City or To	Street and wn, State,	d Number or Ru	ıral Route Numi	ber,
	Physician: To the best o										
one)	aminer: On the basis of and manner sta					th occurre	ed at the time				)
29h. Signature and title of certifier	4 .			29c. Licens	se number			29d. Dat	e signed (Monti	h, Day, Year)	

BA 4 State

STEVEN 31. Date filed (Month, Day, Year)

JUL 10

he and address of person who completed cause of death (Item 23a) (Type, Print)

2007

M.D. 100 E. CARNUL St. SAlisbury Md. 21801
32. Pygistrar's Signature

Registrar

			1 - For State Registrar	State of M	Marylar				ealth a Death			giene Reg. No.	007	23707		
	Physici	an	Decedent's Name (First, Middle, I	Last)							2. Date of De Month	ath Day	Year	3. Time of Death		
4	/Medic		Daniel Daniel	Baker							July_	5	2007	10:10 p M		
1.	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park								4c. County of Death Prince Georges					
		See .		6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth								-				
	Funeral Director			1 5 M 2 □ F QQ Yrs. Months Days Hours Min								ıy, Year)	Col	place (State or Foreign intry)		
	Y .		225-10-5632 Usual Residence of Decedent		20						May 4,	1917	Vir	ginia		
	nylan show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits		
	Ba-1 e	cto		Georges	HZ	attsvi	11e							1 ☐ Yes 2 XNo		
	th with th		106. Street and Number 107. Zip Code 109. Citizen of What Cou									intry?				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event, Ite Medical Exactles Intelliged at ODGs.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:						14. Race - American Indian, Black, White, etc.					
Baltimore, Maryland 21215-0036	hin 72 ho a. n. "natur Medicel	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	16a. Deced (Give life. L	dent's Usu kind of wo DO NOT u	al Occupa ork done d use retired	ation luring most	t of worki	16b. Kind of Business/Industry							
21	or the	Son	6	iver					Fed.Government							
nd	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, La	st)									Maiden Sumame)			
<u>Y</u>	ould Men Marka	၉	James Baker								th Loma					
Mar	12 sh h and h and 7 is m traum		19a. Informant's Name/Relationship									-	or Town, State, Zip Code)			
e,	1 and Health em 2 ther 1		Willa Blackwell  20a. Method of Disposition	(Niece)	20b. F	7065 Place of Dispo			urn, I		am, MD.2		tion - City or T	own State		
Ö	ages nt of t: if it		1X Burial 2 ☐ Cremation 3		te / C	comfor	natory or o	other plac		7–10-			•			
Ħ	permit. Pag Department Important: I any injury c		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		ric .								fax Co.	, , VA.		
Ba	Dep impo		Judit K Minsu- 311 N. Patrick St., Alexandria, VA. 22314										, +			
	Physician		Immediate Cause (Final disease or condition			h. Do not ente		de of dyini	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death		
	/Medical Examiner		Due to (or as a consequence of):													
	P =	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury		ertension x sequence of:											
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Chronic Obstructive Pulmonary Diseas								e				
8760,	icate be executed physician and s the burial-transit	dlcal E		,		holest	erole	emia								
9	ntifica ng ph as th	Med	IF FEMALE:													
P.O. Box	The law requires that the death certificate be executed lie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	regnancy oecify)				23d. Date of delivery Month Day Year								
s, P.	res that tigned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?					
ord	requir	ted	24a. We aut								101	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown				
l Rec	Physician: The law requir r this certificate has been si rral director, page 2 should b	Completed										topsy prior to completion of cause of death?				
ita Ita	cian: ertific actor.	Be (	25. Was case referred to medical examiner?						26. Place	of Death	eath Check only one					
Division of Vital Records,	g age	on: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital:							ome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred					
Sio	uttendi death. ctor: A y the fu	cat	2 Accident investigati 3 Suicide 6 Could not	he	1		М		'es 2 □ N							
DIV	2 2 2 2	Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)										n (Street and Number or Rural Route Number, Town, State)			
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical (	29a. Certifying F (Check only one) 2 Medical Ext	Physician: To the bea aminer: On the basis and manner	of examinal	wledga, donth tion and/or inv	Secured	at the tim , in my op	a, date and inion, deat	d placs, a h occurre	nd dus to the od at the time,	caus (s) an date and pla	d manner as t ace, and due t	stated. o the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290	c. License	number			29d. Date s	igned (Month,	Day, Year)		
)			Kayal D	as gupla				646	99			7/6	5/07	7		
1	(7)		30. Name and address of person who	completed cause of	death (Item			\dara=	7600	Cai	roll A			Park,MD.		
1886	Sta	te	Kajal Dasgupta 31. Date filed (Month, Day, Year)	Hospital 32. Regis	trar's Signa	asiiTiik.	COII F	au ven	LIST	nosp	ııaı					
***	Registr	ar	JUL 1 0 2007	32. Regis	D. 19	person										

**Funeral** Director

DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	baltimore, maryland 21213-0036
ital or Attending Physician: The law requires that the death certificate be executed	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan
	Department of Health and Mental Hygiene.
ral Director: After this certificate has been signed by the aftending physician and	
led in by the funeral director, page 2 should be detached for use as the burial-transit	any injury or other traumatic event, the Medical Examiner must be notified at
e	

		For State		State o	f Marylar	,	partment of F ertificate of			, ,		2007	02700			
		Registrar  1. Decedent's Name (First	Middle, L	ast)				Death		2. Date of Dea	th	UUI	3. Time of Death			
hysici: /Medic		Nativida	ıd	Ε.		autist				July 3,			9:06 P M			
Examin	ier	4a. Facility Name (If not in Southern Mary)		_	mber)		4b. City, Town, c		of Death			county of Death rince Geo				
uneral rector		5. Social Security Number 579–54–6727		Sex 1 □ M 2 xxx	7. Age <i>(In yrs.</i>	. last birthda Yrs.	y) If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month Day Aug. 13,	1921	9. Birth Cou Phi I	place (State or Foreign ntry) ippines			
at			County		10c. Ci	ity, Town or							10d. Inside City Limits			
28a-f sh otified	Director	Maryland Prince George's Ft. Washington  106. Street and Number 106. Zip Code									1 □Yes 2 XXNo					
23a or ust be	ral Dir	11608 Hickory		20744				10g. Citizen of What Country? USA								
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 3 XXVidowed 4 □ D		3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Specify:		ecify Yes or No- Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: Filipino								
than "nati he Medica	Completed	15. Di (Specify only Elementary/Secondary (		Education rade completed)  4 College (	1-4or 5+)	(Gin	ve kind of work done	dent's Usual Occupation  kind of work done during most of working  DO NOT use retired)  Countant					16b. Kind of Business/Industry Federal Government			
ced other	Be	17. Father's Name (First, i		nriquez		1		18. Mother's Name (First, Middle, Maiden Surname)  Asuncion Brosoto								
7 is marl traumati	T <sub>o</sub>	19a. Informant's Name/Re Ascuncion Sue	elationship	(Type. Print)	nter	1	illing Address (Street						'			
nt: If item 2 ry or other		20a. Method of Disposition 1 ॲ Burial 2 □ Cren 4 □ Donation 5 □ C	nation 3	☐Removal from	20b.	Place of Dis cemetery, c	position (Name of rematory or other pla Nat. Cemete	ce)		ate	20c. Loc	ation - City or T	own, State			
Importa any inju once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745											ome PA			
sician		23a. P. 11 E Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A The Roscle notic Candio Visical Dislate  Sy.														
aftending physicia I for use as the bur	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Onset and Death  Due to (or as a consequence of):  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):														
	ysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2XX No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown									23d. Date of delivery  Month Day Year					
ı signed by Id be detad	d by Ph	Part II. Other significant	l.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably												
ate has beer page 2 shou	Completed										24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No  24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
certific ector,	Be	25. Was case referred to medical examiner?								(Check only one)						
: After this e	tion: To	1 ☐ Yes 2 XXIo  27. Manner of Death  1 XXI Natural 5 ☐  2 ☐ Accident	Pending investigation	28a. Date (Mor		28b. Time Injur	e of 28c. Inju				e 5 ☐ Residence 6 ☐ Other (Specify)  d. Describe how injury occurred					
I Director d in by the	Certification:		3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 2								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ne Funera	edical (			aminer: On the b			eath occurred at the trinvestigation, in my									
100 Comb	Me	29b. Signature and title of	certifier	- N	1.1		29c. Licen	se number	36-			signed (Month	, Day, Year)			
BI		30. Name and address of Michael Sidar									ŀ					
Sta Registr		31 JUL 1 0 200	Year)	32. F	Registrar's Sign	nature	_									

12. BJ

Division or Vital Records. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; f

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature

and title of certifier

31. Date filed (Month, Day, Year)

Dennis M. DeShields, M.D.

JUL 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0053110

219 S. Washington St., Easton, MD

29d. Date signed (Month, Day, Year)

		1	For State Registrar	State of Maryland	•			ealth and N Death		jiene	007	23710		
Phys			Decedent's Name (First, Middle, Last)	Franklin		Во	rror		July 7,		Year	3. Time of Death 5:43 P M		
Exan	dica ninei	_	4a. Facility Name (If not institution, give s 116 Cree Drive	treet and number)		Fores	st Hei				ounty of Death	_		
Funer Directe			333-03-4000	7. Age (In yrs. It	ast birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birth June 17,	1919	Cou	place (State or Foreign ntry) LNOIS		
Maryland	ţ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits  Y Yes 2 □ No			
with the 3a or 28g	Disector		10e. Street and Number 116 Cree Drive			10f. Zip	Code 207	45		10g. Citize USA	n of What Cou	intry?		
portition of the proof of the p	by European	2	11. Marital Status  1 Never Married 2 Married  3 Married 4 Divorced		39-1	Was Dece f Yes, spe 1  Yes		spanic Origin? (Si n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		Race - Amer Black, White White pecify:	, etc.		
within 72 ho iene. than "natur the Medical	patologo	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	kind of wo DO NOT u	al Occupa ork done d ise retired, S. Na	luring most of wor. }	king	16b. Kind of Business/Industry Millitary						
id be filed ental Hyg ked other ic event,	0	o pe c	17. Father's Name (First, Middle, Last) Perry Ralph Bor	ror				18. Mother's Nan Myrna F		Maiden Su COWN	imame)			
and 2 shou ealth and M m 27 te mar	•		19a. Informant's Name/Relationship (Ty), Judith Ward - Daug		19b. Mailir 26700	og Addres O Mar	s (Street a	or.,Mecha	ral Route Numbe nicsvill	r, City or 7 Le, MI	own, State, Z 20659	ip Code)		
Pages 1 and the first of the first or other ity or other			20a. Method of Disposition  1 1 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	( C	lace of Dispo emetery, cren land Vet	natory or	other place	tery July	Date 13,2007		tion - City or 1 tenham	rown, State , Maryland		
permit. Departments Imports any Inju	once.		21. Signature of Funeral Service Lights	des				ss of Facility Ge 11 Road Ox	_					
Physicia	â		23a. Party Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	n. Do not ent	0		and-	1 //		Disea	Approximate Interval Between Onset and Death		
/Medic Examin	al		resulting in death)	Due to (or as a consequence of the second		- L c	, <i>ò</i>		-			Landenows		
of ou, cate be executed bysicien and the burial-transit		cal Examiner										len teneral		
death certific e attending point to use as		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	⊒Ectopic p ⊒ Other (s	oregnancy specify)			23	d. Date of deli Month	very Day Year		
requires that the seen signed by the hould be detached											Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Michaelman			
10 to 00 cm		Completed by				24a. Was autop perfo 1 Yes	utopsy prior to death?		topsy findings available completion of cause of					
OT VITAL Physician: 1 This certifice		Be	25. Was case referred to medical examiner?	Hospital:			Oth Oth	or	ath (Check only o					
ng Phy (fler this		ition: To	1 Yes 2 No Canal Yes  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injur Wor	4   Nulsing r		asidence 6 Other (Specify) se how injury occurred				
UNISION Hospital or Attending 24 hours after death. Funeral Director: After		Certification	2 Accident 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or to City or Town, State)									ural Route Number,		
the Hospita hin 24 hours the Funera		edical C	29a. Certifier 1  Certifying Phy (Check only one)	sician: To the best of my known or: On the basis of examination and manner stated	wledge, deat ition and/or in	th occurre ivestigation	d at the tir on, in my o	me, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)		
To th To th		ğ	29b. Signature and the of certifier	enolls)		2	9c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)		
o m			30 Name and address of assent who of	completed cause of death (Iter	n 23a) (Tvn=	Print1 A	rasto	oo Yazdan	i. M.D.	س	727	10.1		
U	1Va		30. Name and address of person who c	STONES	Fas		sh		nD 20	74	Y			
Rec	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	out)	-		•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Lola Alberta Reaver 9, 2007 6:20 a M July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Rethesda Montgomery 8. Date of Birth (Month, Day, Year) May 16, 19 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 M 2 X F Yrs 1921 86 Virginia 577-12-9199 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 🕱 No notified Directo Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or : 20906 USA 3466 Gleneagles Drive Funeral death ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21K No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M Federal Government Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Cleveland Beaver Helen Lee Alexander ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Beaver/Brother \$589 S. Leisure World Blvd., Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 1 ☐ Burial 2 ☐ Demand... 4 ☐ Donation 5 【NOther (Specify) Entembment Parklawn Memorial Park 2007 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis Address of Facility Funeral Home Inc. 500 University Blvd, W., MD 20901 Silver Spring, anes Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CAPDIOPULMONARY **Physician** /Medical Examiner MYOCARDIAL INFARCTION Gaueritally list sortalitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine AOKTIC The law requires that the death certificate be executed CHITICAL burial-tra Due to (or as a consequence of) physician Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 donknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy perform 1 Yes 2 -MC Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 20 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Tes 2 🗌 No within 24 hours after death.

To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier

į D

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

Registrar
DHMH 17 Rev 1/2001

State

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

O MD

32 egistrar's Signature

-OTELLO

31. Date filed (Month, Day, Year)

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00052774

8600 OLD GEORGETOWN ROAD BETHESOM MO

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after cleath.

To the Funeral Director: After this certifica completely filled in by the funeral director.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatu 2 d cause of death (Item 23a egistrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 6:45P M 2007 July James Barnes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 17, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6 Sex **Funeral** Days Hours Min 1**X** M 2□ F Yrs 58 1949 Director Maryland 212-48-0991 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural" or items 23a مه 28a. وماسيد 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 340 Winslow Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1™Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wireless Konnection Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked i any injury or other traumatic ev Martha Barnes William Henry Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Winslow Road, Oxon Hill, MD Lisa V. Robinson-Barnes/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 7/16/2007 4 Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Dhewar Mrc reter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immediate : use (Final disease or comittion resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ♣ o 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Z No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 5 within 24 hours a To the Funeral I 1 descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) D0037066 beogu, M.O Oxon Hill, MD20745

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 3, 2007 **Physician** 3:50 A. M Catherine E. Barnett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6250 Franklin Gibson Road Tracys Landing Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Yrs. 80 217-80-9417 September 15, 1926 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worde r than "natural", or Itama 23a or 28a-f ehov the Medical Examinar must be notified at 1 ¥Yes 2 □ No Director Maryland Anne Arundel Tracys Landing 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6250 Franklin GIbson Road 20779 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Be Completed by 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Danestic Engineer Housekeeping traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ges 1 and 2 should be fill tof Health and Mental Hill it item 27 is marked ott Percy Simms Agnes Belt ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Diane Barnett-McPherson(Daughter) 6250 Franklin Gibson Road Tracys Landing, Maryland 20779 other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 \$ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery July 12, 2007 Chelterham, Maryland = 5 Department in important: if any injury or once. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 23a. Anti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Deabitus Ulcer Examiner use as the burial-transit Hospital or Attending Phyaician: The law requires that the death certificate be executed Alzreiner - Demen is that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month ģ Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð page 2 should be 1 Tyes 2 No 3 Probably 4 ☐Unknown Be Completed Diabetes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 214 No 1 Tyes 1 🗆 Yes **3√√N**0 director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier XCartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) JUL 11 2007 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Drive, Suite 310 Prince Frederick, MD 20678

29b. Signature and title of certifier

29c. License number

D50233

29d. Date signed (Month, Day, Year)

07/09/2007

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:20 a M July 09 2007 LANA MAE BAUSERMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 👿 F Director Yrs 58 Maine 579-64-6846 10-31-1948 Usual Residence of Decedent f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event. The Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Prince George's College Park or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 U.S.A. 4812 Erie Street 20740 Funera , or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White ğ 3 ☐ Widowed 4 X Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. ant: If item 27 le marked other than Elementary/Secondary (0-12) College (1-4or 5+) Electrical Union 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald B. Reid Theresa Mather 2 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda A. Reyes -Sister 11374 Cherry Hill Road, #303, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite eny injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/11/2007 Alexandria, Virginia 21. Signaline Funeral Service Landies 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 234. Part 1. Enter the disease, outcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastat mcreatic **Physician** UM KNOWA /Medical Due to (or as e consequence of): Examiner RIN Un known Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes Unknown Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical nowr IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 Yes 2 X № 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🔯 No 1 ☐ Inpatient 2 X ER/Outpatient 3 DOA his After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 57692 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drewry James White, MD 1300 Piccard Drive, Suite 202, Rockville, MD 20850-4303 32, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 7-11-07/Amend#7.PerFHPCCcr Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200 Month 11:00PM **Physician** DURNS bhn LOUIS 07 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner VILLA ROSA MUZSING Home HITCHEUVILLE PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1**X**M 2□F LOCKY LARCOLING 245-09-5724 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Modical Examiner: sust be notified at 1 Yes 2 No DULLAS FLUSHING Director 10e. Street and Number 10g. Citizen of What Country? USA 7161 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Iter any injury or other traumatic event, the Mulcal Experiment 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 Specify. Specify BLAUC þ ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) PRIVATE College (1-4or 5+) WAITER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANDREW BURNS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON James Laftow WASH OR 20012 7 EWKSBURY PLACE NW 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State GAST ELHHERST. NY MICHAEL'S CEMERCY 9/14 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SY MW DC 20011 23a. Part1. Enter the disease, or complications that cave the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WSTUTE Physician Houths /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the first mostly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and the detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗙 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Hospital o 24 hours aff e Funeral Di (x) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie WD completed cause of death (Item 23a) (Type, Print) 30. Name and address of person y

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 1 2007

32. Registrar's Signal

			State of Maryland		rtment of H			/	007	23717
			Registrar  1. Decedent's Name (First, Middle, Last)	061	incate or L	Jean	2. Date of De	Reg. No.		3. Time of Death
r	Physici		Charlotte Oscar Barrick	c			June :	30, Day	2.00 <b>.7</b>	4:58P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	ounc .		ounty of Death	14.501.
			24837 Showbarn Circle		Damascus	3		l n	Montgome	erv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birthr	nace (State or Foreign
b	Director		155-14-0900 85	Yrs.			Dec. 17	7, 192	21 New .	Jersey
	rland ow		10a. State 10b. County 10c. City, T	own or Loc	ation				1	I0d. Inside City Limits
	Mary P-f sh	tor	Maryland Montgomery Dama	scus						1 □Yes 2□No
	th the or 28g	Director	10e. Street and Number		10f. Zip Code			10g. Citize	en of What Cour	ntry?
	23a cust b		24837 Showbarn Circle		20872			Unite	ed State	es
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 4 □ Discoord  1 □ Yes 2 □ No If Yes, Give	lf lf	Vas Decedent of His Yes, specify Cubar □Yes 2점No	spanic Origin? (Spent) n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		I. Race - Americ Black, White, Specify: Whi	etc.
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212	d with giene rr than	mo	Elementary/Secondary (0-12) College (1-4or 5+)		Homemak	ker		Own	n Home	
9	<u> </u>	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name		•	urname)	
<u>S</u>	should be I ind Mental I is marked of umatic eve	임	Oscar Robinson				h Gates	<del></del>		
Maryland 2121	2 shu nand is m				•	nd Number or Rura				•
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ñ	permit. Departr Imports any inj		1664			O.				yland 2190
	*		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.							Approximate Interval Between
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1	/Medical		resulting in death)  Due to (or as a consequen			,,,,,,				DOLL ENTERON
	Examiner	_	Sequentially list conditions, b.							
	ied isit	Examiner	Sequentially list conditions.  Later Later Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events  C	ce ori:						
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Ó	tificat g phy as the	ledic								
). Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	eath 3 🗌	Ectopic pregnancy Other (specify)			23	d. Date of delive Month	ery Day Year
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	rsician: The law s certificate has b lirector, page 2 sf	Completed					24a. Was auto perfe	psy ormed?	prior to co death?	opsy findings available impletion of cause of
VItal			25. Was case referred to medical			26. Place of Death	1 Yes	2 No	1 ☐ Yes	2 No
	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER.	/Outpatient	3 DOA Othe				☐Other (Specia	fv)
0 0	ding Physics I. After this funeral di	ı.i.	27. Manner of Death 28a. Date of Injury 28 1 Natural 5 □ Pending (Month, Day Year)	Bb. Time of Injury	28c. Injury Work		28d. Describe			
<u>                                      </u>	tendil eath. or: A	atic	2 Accident investigation		M 1 🗆 Y	/es 2 □ No				
DIVISION	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Run	al Route Number,
	pital ours a eral [ filled		29a. Certifier Certifying Physician: To the best of my knowle	dge death	occurred at the tim	ne date and place	and due to the	raneo(e) a	and manner as a	etated
	24 ho 24 ho 5 Fun etely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	and/or inv	restigation, in my op	pinion, death occur	red at the time	, date and p	place, and due t	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	number		29d. Date	signed (Month,	Day, Year)
			> Sur Jax UN)		D3	8076	,	Jul	43,2	2007
	10		30. Name and address of person who completed cause of death (Hom 23	a) (Type)					t	
\$	Sta	- 7	31. Date filed (Month, Day, Year) 32. Registrar's Signature	frank.	2					
	Registr	ar	JUL 1 0 2007 Block St A	MAN TO						

07-05010 Chad A. Backus

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		I- For State Criticate of Death Registrar	Re	g. No.	
Physicia Physicial Examin	-	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month July 1, 200	Day Year	3. Time of Death 0317 hrs
3		Chad     A.     Backus       4a. Facility Name (if not institution, give street and number)     4b. City, Town, or Location of Death		4c. County of Death	
		Addison Rd & Ronald Rd Capitol Heights		Prince George	
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 6. Sex 1 Age (In yrs. last birthday) 6. Sex 1 Age (In yrs. last birthday) 6. Sex 1 Age (In yrs. last birthday) 6. Sex 1 Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 9. Age (In yrs. last birthday) 1. Age			thplace (State or In United <sup>untry)</sup> States
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daryland 28a-f show 1 at once.	5	MD Prince Georges District Heights			1 X Yes 2 No
the N	E e	10e. Street and Number  1626 Addison Road South  20747		og. Citizen of What Cou Jnited Stat	
eath with	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 16. Was Decedent of Hispanic Origin?		14. Race - Amer White, etc.	ican Indian, Black,
after d	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	۷. ,	Specify: Bla	
1215-0036 de filed within 72 hours a fental Hygiene. arked other than "natural vevent, the Medical Examin		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)   College (1-4 or 5+)   College (1-4 or		16b. Kind of Business/	Industry
036 rithin 7 ene. rr than	Completed	12 Barber		Cosmetolo	gy
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	ပ္ပို	17. Father's Name (First, Middle, Last)  William Kemp Backus  Paula I	e (First, Middle, M D. Higdo		
212 212 ould be Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F			e, Zip Code)
AD 2 and 2 shoul lealth and M tem 27 is in traumatic		Naima A. Reed/Wife 1626 Addison Road Sou			
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is highly or other traumat		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/9	Date 9 / 0 7	20c. Location - City or Suitland,	
Itim iit. Pag artment ortant:	-	4 Donation 5 Other Specify: Cedal RIII CellieLeTy // 21. Signature of Funeral Services Licensee 22. Name and Address of Facility B10			
Dept.		Joanna C. Cliberry 1632 Crittenden St	t., N.E.	Wash., D.	
Physician //Medical		23a Part I. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
<b>Examiner</b>		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):	-		Death
	_	Sequentially list conditions, b			
	Examine	if any, leading to immediate cause. Enter Inderlyin, Cause (Disease or injury that initiated			
760, cate be executed physician and the burial - transit		events resulting in death) Last  Due to (or as a consequence of):  d.			
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Box 68's e death certification the attending ed for use as	ysician	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown		İ	103
P.O. B. that the de ned by the detached is	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
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Vita ysicia ysicia	To Be	examiner?	ng Home 5	Residence 6 🗸 Othe	r: Scene
Division of Vital Records, P.O rea or Attending Physician: The law requires that trs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury Jul (1, 2007), Year)  28b. Time of Injury 28b. Time of Injury 0250 hrs  1 Yes 2 ✔ No		now injury occurred co/auto collision	
Divisi tal or Att rs after de al Direct led in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street		Street and Number or Ritate) Ronald Rd, Capitol	ural Route Number, City Heights, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and constant of the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the caus	e(s) and manner as sta	ted.
H W H 8	Me	29b Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
		( alaberry O.C.M.E.		July 1, 2007	
R/12/	1	30. Name Lattress of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
St: Regist	ate	31. Date filed (Month, Day Xear) 32. Registrar's Signature	<del>.</del>		

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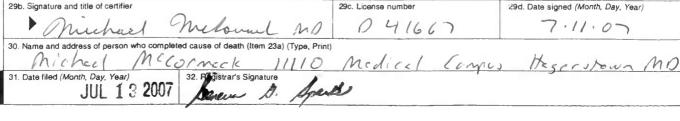
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otato of Mic		•	tificate of	f Death		Reg. No.	007	23719
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Harry J. Carey 4a. Facility Name (If not institution, give	stroot and numbers			4h City Town	or Location of Death	7	40.00	67	0815 AM
)	Examin	er	Castel Hospice A								Wicomico	
	Funeral		5. Social Security Number 6. Sex	7. Age		ast birthday)	If Under 1 Year	ur Under 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign
	Director		214-32-1152	M 2□F 7	72	Yrs.	Months Day	s Hours Min.	(Month, Da 3-27-19	9, <i>rear)</i>	Mary	land
	and ww		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ation				1	0d. Inside City Limits
	Maryl -f sho iied a	tor	MD Wicomico	,	Heb	ron						1 ☐ Yes 2 🖔 No
	r 28a	irec	10e. Street and Number	<u> </u>	1100	1011	10f. Zip Code	,		10g. Citizen	of What Cour	itry?
	th wit	al D	8676 Memory Garder	l Lane			2183	0		USA		
	tems	Funeral Director		12. Was Decedent E Armed Forces?		3. 13. V	Vas Decedent of Yes, specify Cu	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. F	Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland ttal Hygiene.  Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo	1	□Yes 2XN	o Specify:		Spe	ecify: Whi	te
Ş	2 hou latura ical E	ted	15. Decedent's Edu	cation		16a. Deced	ent's Usual Occ	upation	t to a	16b. Kind o	f Business/Inc	dustry
21215-0036	filed within 72 Hygiene. rther than "na rth, the Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)			ne during most of wor red)	King			
	filed wi Hygier ther th	Co	6			Roo	fer	10. Mathada Nan	on /Finch beindalla		struct	ion
Maryland	d be findal Hed other	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ie (Fifst, ivilaale,	_	,	
Ž	s 1 and 2 should be if Health and Mental item 27 is marked other traumatic even	ဍ	Lester Car  19a. Informant's Name/Relationship (Ty	ey, Sr. pe. Print)		19b. Mailin	g Address (Stre	Annie et and Number or Ru	ral Route Numb	Sava er, City or To		Code)
<u> </u>	1 and 2 s Health ar em 27 is other trau		Mary Katherine Car	ev - wife	;			Garden Lar		-		,
ē,	ss 1 a of Hei item		20a. Method of Disposition			ace of Dispo	sition (Name of natory or other p	lace)	Date		on - City or To	
Ĕ	Pages nent of I ant: If ite ury or o		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )	lemoval from State			Cemete	1	1-07	Libert	ytown,	Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or otl once.		21. Signature of Funeral Service Licens	ee GA	1	22	. Name and Add	Iress of Facility	Bounds F			
_	20 5 8 0	1	TIJUISON THE	my So	ine			in Street,			arylan	
			23a. Part . Enter the disease, or compleshock, or heart failure. List only of	ne cause on each lin	the death ie.	. Do not ente	er the mode of d	ying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Colon			e my	& hiver	Mel	03/2	us	zyrs
	Examiner		- 1	Due to (or as a	a consequ	ience ot):						
- 400	2	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a	a consequ	ence oi).						
	cuted nd transit	Examiner	that initiated events	o								
Ď,	rificate be executed g physician and as the burial-transit	E	resulting in death) Last	Due to (or as a	a consequ	ence of):						
68/60,	icate t physic	ledical		i								
			IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome p	pf pregnai	ncy				23d.	Date of delive	erv
. Box	death cerl e attendin d for use a	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			Ectopic pregnar   Other <i>(specify)</i>	ncy			Month	Day Year
7. O	at the de by the a rtached	hys	9 Unknown	9□Unknown		<del></del>						
	The law requires that the te has been signed by the hage 2 should be detache	ру Р	Part II. Other significant conditions con	ntributing to death bu	ıt not resu	Iting in the ur	derlying cause o	given in Part I.				ne cause of death?
0	requii een s nould								10	Yes 2 N	o 3   Prot	pably 4 □Unknown
Kecords,	elaw hasb je 2 sh	Completed							24a. Was	osy	prior to co	psy findings available mpletion of cause of
<u></u>	sician: The la certificate ha rector, page 2								1□ Yes	2 A No	death? 1 ☐ Yes	2 <b>⊠</b> No
Vita	siclan: certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	fospital: 1 ☐ Inpatie	nt 2 🗆 1	ER/Outpatien	2000	26. Place of Dea				· il 10
Ö	a Phy er this eral d	F-1	27. Manner of Death	28a. Date of Injur	y	28b. Time of	28c. In	jury at	28d. Describe I			nHospice
0	ath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	(Year)	Injury		/orƙ? □ Yes 2 □ No				
UIVISION	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju	ry - At hou	me, farm, stre	eet, factory, offic	e	28f. Location (8 City or Tox		ımber or Rura	al Route Number,
	pital or At burs after d eral Direc filled in by			4				7)				
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pa	Medical	29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best on ner: On the basis of and manner sta	examinat	wedge, death ion and/or in	occurred at the estigation, in m	rume, date and place y opinion, death occu	e, and due to the urred at the time,	date and pla	manner as s ce, and due to	rated. the cause(s)
	o the	Med	29b. Signature and title of certifier				29c. Lice	nse number		29d. Date sig	gned (Month,	Day, Year)
)	1/2		Swanne h. l.	Sellow	. A.	2	D.	29505		07-	07-1	27
, \	100		30. Name and address of person who co	ompleted cause of de	eath (Item	23a) (Type,	Print)			- 1		- 1
	<b>V</b> \	-	GREGORIO M. B				2 CHINA	BERRY DE	., SALI	SBUR	Y, MD	21801
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ture						

			For State Registrar	State of Maryland	•	rtment of H tificate of L		•	Glerie)	23720	
			Decedent's Name (First, Middle, Last	ŋ				2. Date of De		3. Time of Death	
	Physicia		Howard	Raymond		Case		Month	Day Yea		
	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death	1	4c. County of De		
			Washington Count	y Hospital		Hagers	town		Washington		
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	***	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th 9. E	Birthplace (State or Foreign Country)	
	Director		217-18-4999	XIM 2□ F 83	Yrs.	Working Days	Trours IVIIII	July 1		Maryland	
	pu >		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	cation				10d. Inside City Limits	
	anyla shov dat	_								1 □Yes 2 No	
	Ba-f	Director	MD Washing	con Ha	gersto				40-025		
	a or 2	ä	10e. Street and Number 17020 Oakleigh W	217		10f. Zip Code 21740			10g. Citizen of What		
	s 23	Funeral		12. Was Decedent Ever in U.S	S 13 V		ienanic Orlain? (Sp.	acify Ves or No		merican Indian,	
	item item	اجّ	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 X Yes 2 No 194.	.3	Was Decedent of Hi f Yes, specify Cuba X	in, Mexican, Puerto	Rican, etc.)	Black, W		
336	be filed within 72 hours after death with the Maryland ntal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ργ	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates: 194.		1 □ Yes 2ဳ No	Specify:		Specify: W	Thite	
ŏ	2 hot		15. Decedent's Ed	ecation	16a. Deced	dent's Usual Occupa	ation		16b. Kind of Busines	ss/Industry	
212	hin 7 e. gn "n Medi	Completed	(Specify only highest grade	College (1-4or 5+)	life. L	kind of work done o DO NOT use retired	during most of work ()	ing	ŀ		
2	d with	ĕ	4	g- (,	Machi	ne Operat	or		Textile		
pu	should be filed nd Mental Hygi marked other matic event, <u>ti</u>	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	, Maiden Surname)		
<u>a</u>	should be fand Mental B s marked of umatic eve	2	Robert James Case	<u> </u>			Margare	t Beema	ın		
Maryland 21215-0036	an s		19a. Informant's Name/Relationship (7)	ype. Print)	19b. Mailir	ng Address (Street a	and Number or Rur	al Route Numb	er, City or Town, State	e, Zip Code)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Jacqueline C. Mi			20 0aklei				21740	
ore	000		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		sition (Name of natory or other plac		Date	20c. Location - City	or Town, State	
Ĕ	Pages ment of ant: If its ury or o		4 □ Donation 5 □ Other (Specify			rg Cremat			Smithsbu	0.	
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licens	ee ·	22	2. Name and Addres	ss of Facility Res	st Have	n Funeral	Chapel	
	205 40		S. Warle.	Say	16	601 Penns	ylvania A	ve., Ha	agerstown,	_	
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	ırrest,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	a Severe H	yper 10	3/em12	Cousi	My C	adeac	Short and Boats	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ier e of):			)			
	Lxammer		Sequentially list conditions,	b. Annosi							
	ed sit	ine	if any, leading to fininediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	,	400	0000		1		
	and -tran	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ		Nroute	1000	Tell	core.		
9	be ey ician buria			Carman	,	yey 1	rend	500	ese		
68760	ifficate be executed g physician and as the burial-transit	edical		d		)0-1	10000	, 500			
_			IF FEMALE:	23c. If yes, outcome pf pregnar	ncy				23d. Date of	delivery	
Box	attending for use a	ciar	in the past 12 months?	1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1		Month	Day Year	
О	y the	Physician/M	1 ☐ Yes 2 ☐ ¶o 9 ☐ Unknown	9□Unknown		(1,, ,					
т. Г	he lav requires that the death cer te has k een signed by the attendin age 2 should be detached for use		Part II. Other significant conditions co	ontributing to death but not resu	ılting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?	
Records,	quires n sign	q p	Myperfersion					1 🗆	Yes 2 2 1 1 1 3 □	Probably 4 ☐Unknown	
8	av require s keen sig s hould b	Completed by	DI GREFES M	ecche m	0 2			24a. Was		autopsy findings available	
	he lav te has age 2 :	шо	0421416	- curric	DUE	are		auto perfe 1□ Yes	ormed?death	to completion of cause of of of the completion of cause of of cause of cause of	
Vital		Be C	25. Was case referred to medical		1708		26. Place of Deat			63 20110	
	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☐ 100	Hospital: 1 □ patient 2 □ E	ER/Outpatier	nt 3 DOA Othe	or.		idence 6 □Other (S	pecify)	
0	Attending Physician: r death. ector: After this certifici by the funeral director,		27. Manner 1 eath 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe	how injury occurred		
<u>0</u>	tendir leath. tor: Al	atic	2 ☐ Accident investigation				Yes 2□No				
Division or	or Attendater death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office			Street and Number or wn, State)	Rural Route Number,	
	pital cours af			1							
	Hos 14 hr Fun tely	edical		ysician: To the best of my know niner: On the basis of examinat							
	To the Hos within 24 hd To the Fun completely	Med		and manner stated.		29c. License	e number		29d. Date signed (Me	onth. Dav. Year)	
	8 1 × 1		7 0 1	hospitalist						7	
-			· June &	and and	00-) (T	17(00	4111/		July 12	1001	
X	12+	- 1	20 Name and address of narcon who	mostly report to desired hatalming		Print)	The same of the sa				
~	PJJ		30. Name and address of person who	. /	23a) (Type,	Print) 25(	t. Antie	How S	2/7/0	30	
	Sta	te_	30. Name and address of person who of the control o	) on rels Do		Print) 25(	61117 E- Antie	of MY	21740	10	

			_ For		<b>int in Black In</b> Maryland / Depa	artment of H	lealth and M	-	1 7	7 23721
			1 - State Registrar		Cei	tificate of	Death		Reg. No.	
	Discosta i		1. Decedent's Name (First, Middle, Last	)				2. Date of De Month		3. Time of Death
	Physici /Medio		Leonard Dolph C	ampbell				July		007 3:00 AM <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give		r)	4b. City, Town, o	r Location of Death		4c. County of	
	Funeral		1320 Woodland W 5. Social Security Number 6. Se	x 7. A	lge (In yrs. last birthday)	If Under 1 Year	lagerstown	8. Date of Birt (Month, Da		hington County  9. Birthplace (State or Foreign
	Director		175-24-9299	M 2□F	73 Yrs.	Months Days	Hours Min.	Jan 3		Pennsylvania
D			Usual Residence of Decedent	•	Ţ					
death with the Maryland	Sa-f ehow	ctor	Maryland Washin	gton	10c. City, Town or Lo	Hagersto	wn		<del>-</del>	10d. Inside City Limits 1 ☐ Yes 🏋 ☐ No
th with th	23a or 2	al Dire	10e. Street and Number 1320 Woodland Wa	ay		10f. Zip Code	21742		10g. Citizen of W	hat Country? J.S.A.
21215-0036 od within 72 hours after dea	Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23s or 28s-f show say injury or other traumatic event, the Medical Examiner must be rightlied at ance.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 2 Yes 2 If Yes, Give Year or Dates	]No	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		- American Indian, (, White, etc. White
2 P	setur ical	ted	15. Decedent's Edu		16a. Deced	dent's Usual Occup	pation		16b. Kind of Bus	siness/Industry
215 thin 7	Med "	ple	(Specify only highest grad Elementary/Secondary (0·12)	College (1-40)	r 5+)	DO NOT use retired		ng	_	_
2 P	or th	Sol		4		[nsurance	Agent		Insura	nce Company
Maryland	fental Hyrked oth	To Be	17. Father's Name (First, Middle, Last) William D. Camp	bell			18. Mother's Name Flore		Maiden Sumame Yetter C	
ary shou	A pur		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Numbe	er, City or Town, S	State, Zip Code)
Z 2	27 is		Florence N. Cam	pbell - v	wife 1320	) Woodlan	d Way Hag	erstown	Marylan	d 21742
Baltimore,	nent of He int: if item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disponsion Commetery, creme Rose Hill	natory or other place	ce)	Date -2007		city or Town, State
Balt	Departr imports eny inju		21. Signature of Funeral Service Licens	Lung	1;	331 Easte	rn Blvd.	N. Hage	rstown M	uneral Home Maryland 21742
Ex	ysician Medical parial-transit	Examiner	23a. Part1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a consequence of):	4	Melk		rrest,	Approximate Interval Between Onset and Death
. Box 68760, death certificate be execut	ding physician se as the burial	60	IF FEMALE:	d	s a consequence of):					
P.O. Box	been signed by the attending phys should be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year
	an signed b	<u>۾</u>	Part II. Other significant conditions con	ntributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	/	bute to the cause of death? 3 ☐ Probably 4 ☐Unknown
() >	cate has bee page 2 sho	Completed							rmed? of	Pere autopsy findings available for to completion of cause of sath?  Yes 2 No
/ita	ertific octor,	Be	25. Was case referred to medical examiner?				26. Place of Death	Check only o	ле)	
) hysik	his c I dire	2	1 ☐ Yes 2 ☐ Mo		tient 2 ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Hor	me 5 Resid	dence 6 Other	r (Specify)
Division of Vital	ath. or: After ti ne funera	atlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	jury 28b. Time of lay Year) Injury	28c. Injur Wor M 1 [	y at k? Yes 2 □No	28d. Describe h	now injury occurre	d
DIVIS	s after de al Directo ed in by ti	Certific	3 Suicide 6 Could not be determined	28e. Place of Inbuilding, 6	njury - At home, farm, str etc. (Specify)	eet, factory, office	:	28f. Location (5 City or Tox		r or Rural Route Number,
Division of Vita	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the bes ner: On the basis and manners	it of my knowledge, death of examination and/or in- stated.	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)
To th	To the comp	ž	29b. Signature and title of certifier	_		29c. Licens	e number		29d. Date signed	(Month, Day, Year)
A	Å		Muchael	mel	ound M.	0 0	41667		7.	11.07

State Registrar



41 0
Physician
/Medical
Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physiciai /Medica Examine

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Registrar

	For State Registrar	Certifi	cate of Dea	ath		Reg. t	10. Z U U		23/66
ion	Decedent's Name (First, Middle, Last)				2. Date of I		Day Ye	ear	Time of Death
ian ical		arke			July	5,	2007	2	2:08 A. M
iner	4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospita		Clinton				c. County of I	Georg	
	578–18–4508 <sup>1</sup> <b>X</b> <sup>M</sup> <sup>2</sup> □ F		Jnder 1 Year If Unnths Days Hor	nder 24 Hrs. urs Min.	8. Date of E (Month, I	Day, Yea	1916 <sup>9.</sup>	Birthplace Country) Virgin	(State or Foreign
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	n					10d. li	nside City Limits
ctor	Maryland Prince Georges	Forestvi	.11e						Yes 2 No
al Director	10e. Street and Number 7420 Marlboro Pike	10	of. Zip Code <b>20747</b>			_	Citizen of Wha		5
by Funeral		vo June 1941_	Decedent of Hispani s, specify Cuban, Me Yes 2 <b>X</b> No Spe	ic Origin? (Sp exican, Puerto ecify:	pecify Yes or I o Rican, etc.)	No-		American In White, etc. Black	
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8th grade  College (1-4or 5	(Give kind life. DO N	s Usual Occupation of work done during IOT use retired)		king	U.	Kind of Busin S. Gene dminist	eral S	Services
Be C	17. Father's Name (First, Middle, Last)				ne (First, Midd	le, Maid	en Surname)		
To B	Robert Ellis Clarke		h	lary	Elizab	eth	Jones		
	19a. Informant's Name/Relationship (Type. Print)		Idress (Street and N						*
	James Kearford Clarke (Nep		ine Tree	Lane;					
	20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition cemetery, cremator  Mount Oli	ry or other place) <b>vet Cemet</b>	ery	12,200	7	Location - Cit	gton,E	
	21 Signature of Juneral Service Joseph B. Ho	22. Nai R. 600	me and Address of F N. Horton Kennedy S	acility Compa Street	any Mon	tic: lash:	ians, l	nc. D.C.	20011
	23a. Part1. Enter the disea e, or complications tha caused shock, or heart failure. List only one cause on each li	the death. Do not enter the					81,417	Apr	proximate erval Between
	Immediate Cause (Final disease or condition RESP)	RATORY F	ALLURE					Ons	set and Death
		a consequence of):							
	Sequentially list conditions, b. PNEU	noNIA a noneeduence on:							
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 001000,00100 017.							
Exai	resulting in death) Last C. Due to (or as	a consequence of):						_	
call	d								
Medical	15 55 111 5								
Be Completed by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ecto	opic pregnancy er (specify)	<u>.</u>		-	23d. Date o Month		Year
Phy	Part II. Other significant conditions contributing to death b	ut not resulting in the underly	ying cause given in F	Part I.	23e. Di	d tobacc	o use contribu	ite to the ca	ause of death?
d by	DIABETES				1[	Yes	2 No 3[	] Probably	4 ∃⊎ńknown
lete	SEPSIS				24a. W		24b. We	re autopsy f	findings available tion of cause of
omp					au pe 1□ Yes	topsy rformed 2 📈	prio dea	r to comple th? Yes 2□	
Se C	25. Was case referred to medical		26.	Place of Dea	th (Check onl		10		
	examiner? 1   Yes 2   Hospital: 1   Inpatie	ent 2 AER/Outpatient 3	□ DOA Other: 4	☐ Nursing H	ome 5□Re	sidence	6 □Other	(Specify)	
ü	27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Month, Da	y Year) Injury	28c. Injury at Work?		28d. Describ	e how ir	jury occurred		
Certification: To	2 Accident investigation	ury - At home, farm, street, f c. (Specify)		2□No	28f. Location	(Street	and Number (	o <i>r Rur</i> al Ro	ute Number,
				17					-
Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner street.	f examination and/or investi	curred at the time, da gation, in my opinior	ate and place n, death occu	, and due to t irred at the tim	ne cause ne, date	e(s) and mann and place, and	er as stated d due to the	d. cause(s)
Me	29b. Signature and title of certifier		29c. License num		1/10	29d.	Date signed (/	Month, Day,	Year)
	500216		D403	24		1	14 6	, 200	7
	30. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print	1						
	TERRY A. JUDRIE, MD	7503 S	URRATTS	ROTO	CLIM	TON	MARY	LAND	20735

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year $P^{M}$ 11:25 Norma Geraldine Campbell Ju<sub>1</sub>v 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air <u>Harford</u> Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F 215-46-5183 60 Maryland March 11, 1947 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Stephanie Court 21911 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🖔 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Caregiver <u> Home Care</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Richard Barcus Anna Lee Kimbles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence E. Campbell/Husband 101 Stephanie Court, Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Brookview Cemetery 7-12-2007 Rising Sun, Maryland 21. Signature of Funeral 5 ce License 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911

**Physician** /Medical

The law requires that the death certificate be

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Vital

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Hospital or Attending Division

within 24 hours after deatl Fo the Funeral Director:

permit. Pages 1 and Beath Department of Health Important: If item 27 any injury or other traconce.

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

Completed by

Be

ျ

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death with the Maryland

Maryland

Baltimore,

1 and 2 should be Health and Mental

Immedia use (Final disease or condition resulting in death) Examiner Examine

IF FEMALE:

Completed by

Be

Medical Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 No

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 XNatural 2 Accident

3 Suicide

4 Homicide

23a. Part1. Enter the disease, or shock, heart failure. List

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line.

ralignan Due to (or as a consequence of): Due to (or as a consequence of)

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9∏Unknown

3 ☐Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

o months

Vear

Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 ☐ Inpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 KER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes

24a. Was an

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number H40582 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of EMMONTAN RO 31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar

			_ FOI	State of Maryla	•			Mental Hygi	ene	
			1 - State Registrar		Cer	rtificate of	Death	Re	22721	
	Physici	an	Decedent's Name (First, Middle, Last)	0.4				Date of Death     Month	Day Year	3. Time of Death-
	/Medi		Sherwood A.	Clark	1				08 2007	0945 M
	Examir	ier	4a. Facility Name (If not institution, give st	treet and number)		4b, City, Town, o	r Location of Death		4c. County of Death	
			5. Social Security Number 6. Sex	1.01	s. last birthday)	If Under 1 Year	If Uhder 24 Hrs.	8. Date of Birth	Wicome	pplace (State or Foreign
	Funeral Director			M 2□ F 73	Yrs.	Months Days	Hours Min.	(Month, Day, Oct. 26	Year) Cot	intry)
	- NA		Usual Residence of Decedent					0000. 20	, 1999 com	iccercae
į.	Maryland f show	_	10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
-	the Ma 28a-f s notified	Director	MD Dorches	ter		Caml	oridge			1 XYes 2 No
Z	vith th	2	10e. Street and Number	D3		10f, Zip Code	21.612	10	g. Citizen of What Co	untry?
8	72 hours after death with the Marylar natural", or items 23a or 28a-f show dical Examiner must be notified at	era	1417 Stone Bounda	2. Was Decedent Ever in	11.0	Man Donadant of L	21613	and Van au Na	USA 14. Race - Amer	ican Indian
1	iten de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1∑Yes 2□No	0.5.	f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	o Rican, etc.)	Black, White	
21215-0036	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: Kor	ea	1□Yes 2 <mark>K</mark> INo	Specify:		Specify: Wh	ite
9	72 hou natura ical E	Completed	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occup	ation during most of wor	king 1	6b. Kind of Business/I	ndustry
215	d within 72 ho giene. r than "natu the Medical	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	during most or world)	King		
21	filed wi Hygien other th	S	11			manage			power co	ompany
pu	A B B	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	faiden Surname)	
<u>\</u>	nould to	은	Arthur F. Clark  19a. Informant's Name/Relationship (Typ	5:0	401 44 33			Ryder	City or Town, State, 2	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Linda Clark	wife	1	,			ridge, MD	21613
ည်	s 1 and 2 f Health item 27 i	(C)	20a. Method of Disposition	20b		sition (Name of natory or other place			20c. Location - City or	Fown, State
altimore,			1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )	emoval from State		y Cremato	· .	0/07	Salisbury	. MD
Ħ	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service License			-			eral Home 1	
ä	permi Depar Impo any ir once,		I that legran	/		700 Locus	st St., C	ambridge	, MD 21613	3
The state of the s	Physician /Medical Examiner	Examiner	shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equance of):	Lung u	nth Meta	stasia ta	spine	Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	Physician/Medical Ex	d.	Due to (or as a conse	nancy etal death 3□	Ectopic pregnance Other (specify)	y		23d. Date of deli Month	very Day Year
<u>α</u>	s that med b e deta	by Pł	Part II. Other significant conditions conf			nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	w require been sig should b	ed	_ Viabeles	Melli	lees			1 ☐ Ye	s 2∐No 3 <b>⊠</b> Pro	obably 4 □Unknown
Vital Records,		Completed	Essential	Hepen	Jena	con		24a. Was ar autopsy perform 1  Yes 2	y prior to c	topsy findings available ompletion of cause of
Vita	sician; Thi certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		104		th (Check only one	e)	
or	this al dir	은	1 ☐ Yes 2 No	1 ☐ Inpatient 2	ER/Outpatien		4 LI Nursing H		nce 6 🗷 Other (Spec	ity) Hospice
Division	Jing Affe fune	Certification:	1 Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)  28e. Place of injury - At	Injury	M 1 □	yai k? Yes 2 □ No	28d. Describe ho		Don't Alimahan
Div	P He or	Certifi	4 Homicide determined	building, etc. (Spec	cify)	eet, factory, office		City or Town	reet and Number or Ru , State)	rai noute Number,
	e Hospital 24 hours e E Funeral letely filled	Medical		ician: To the best of my k ner: On the basis of exami and manner stated.						
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Monti	n, Day, Year)
			Leegens lan	Bellow	m.D.	P 2	9505		07-08-	2007
			Name and Press of person who cor	npleted cause of death (It	em 23a) (Type,	Print)				
			GREGORIO M. BEL	LOSO, M.D.	5302 0	HINABE	RRY DR.	SALISB	URY, MD	21801
	Sta	ate	31. Date filed (Month, Day, Year)	32. Restrar's Sig	nature	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #2,#8, Amended # 26 **1**- For State Registrar State of Maryland / Department of Health and Mental Hygiene 07/12/07, T.M., Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day C Month Year **Physician** М 6 07 Harrictt attral VIRGINIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hester Kiver Hospital inestertou Kent 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) Social Security Number 214-26-7307 6. Sex **Funeral** Days 1 ☐ M 2 🖫 F Months Hours July 6, 1928 Maryland Director Usual Residence of Decedent August6, with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County worle rthen "netural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at 1 Yes 2 No MD Rock Hall Kent Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4541 Piney Neck Road 21661 USA 2 should be filed within 72 hours after death vinand Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 8 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be trainent of Health and Menta tant: If item 27 is marked jury or other traumatic ex Frank Dwyer Hazel Brooks ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Court St., Chestertown, MD 21620 Alex Rasin, Per.Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. July 12, 2007 Still Pond Cemetery Still Pond, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAG /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): MW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physicien and hed for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown ģ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown ventriuler 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No this certificete Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 catient Other: 2 No 2 1 Tes 2 ER/Outpatient 3 DOA Hame 5 Residence 6 Other (Specify) After the 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28d. Describe how insury occurred 28b. Time of Certification: Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No I Director: A investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D51735 1110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's

200

JUL 12

Frederick Delboy, M.D., 6602 Church Hill Road, Ste 200, Chestertown, MD 21620

			For State Registrar		State of M	arylan	-	artment of H r <i>tificate of</i>		Mental Hy	/gien Reg. N	71111/	23725
33		(F)	1. Decedent's Name	(First, Middle,	Last)					2. Date of D			3. Time of Death
Ş	Physici		C+orro	n D C	amaball Cr					Month July	3	ay Year 2007	6:45A M
1	/Medic Examir				ampbell, Sr give street and number)			4b. City, Town, o	or Location of Dea			c. County of Dea	0 0 1 7 1 1
	LAGIIII		Southe	rn Mars	yland Hospi	ta1			Clinton			Prince	George's
Bar.	Funeral		5. Social Security Nu		6. Sex 7. Ag		last birthday)	If Under 1 Year	If Under 24 Hr		rth	9. Bir	thplace (State or Foreign ountry)
Ю	Director		579-74-08	78	1 🕅 M 2 🗆 F	48	Yrs.	Months Days	Hours Mir	July 12			sh. DC
	D		Usual Residence of I							002) +			
	ylan how at		10a. State	10b. County		10c. City	, Town or Lo						10d. Inside City Limits
	a-fs	ctor	Maryland	Prince	e George's			Сар	itol Hei	ghts			1 □XYes 2 □ No
	th the or 28 e not	Funeral Director	10e. Street and Num	ber				10f. Zip Code			10g. C	itizen of What Co	ountry?
	th wil	<u>a</u>	1218 F	oyer Av	venue .				20743			United	States
	deal sms	ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (	Specify Yes or N	0-	14. Race - Ame Black, Whit	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marrie 3 ☐ Widowed	4.5.	d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No	Specify:	,			slack
ŏ	2 ho	Completed	(Special	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation	orkina	16b.	Kind of Business	/Industry
215	hin 7 8. III "n Medi	ble	(Special Special , , ,	grade completed)  College (1-4or	5+)	life.	kind of work done DO NOT use retire	d) auring most of wi	orking				
21	d wit gient grent the	no.	12th					Computer	Operato	r		Govern	ment
	othe vent,	Be (	17. Father's Name (A	First, Middle, L	ast)				18. Mother's Na	me (First, Middle	e, Maide	n Surname)	
<u>a</u>	uld b Ventz rked	TOE		George	Campbell					A1:	ice	White	
Maryland	sho and h s ma		19a. Informant's Nar	me/Relationshi	p (Type. Print)		19b. Maili	ng Address (Street	and Number or F	Rural Route Numi	ber, City	or Town, State, .	Zip Code)
	and 2 alth a		Beverly	A. Car	mpbell/Wife			8 Foyer	Ave., Ca	pitol He	eigh	ts, MD	20743
ē	of He Item		20a. Method of Dispo				lace of Dispo emetery, cre	sition (Name of matory or other pla	ce)	Date	20c. l	Location - City or	Town, State
Ë	Page lent c nt: If		1 ☐ Burial 2 <u>K</u> 4 ☐ Donation		3 □Removal from State ecify)		T.ee'	s Cremat	orv 7/	14/07		Clintor	, MD
Baltimore,	orta		21. Signature of Für		A			2. Name and Addre			Fun	eral Hor	<u> </u>
m	permit Depar Impor any Ir			mT.	Theward i	11		400	1 Bennin	g Rd., I	NE	Wash., I	C 20019
ħ.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, of heart failure. List only one cause on each line.										Approximate Interval Between
	Physician		Immediate Cause (Final Matartatic / 11/2x ( Buccar)										Onset and Death
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Ć	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) La	ast	Due to (or as	a consequ	uence of):						
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68	4- 07												
.O. Box	uires that the death certific signed by the attending pl Id be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1□ Yes 2□ 9□Unknown	nonths?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	death 3	Ectopic pregnand Other (specify)	У			23d. Date of de Month	livery Day Year
Δ.	that t ed by detac		Part II. Other signific	cant condition	ns contributing to death b	ut not resu	alting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ords,	law requires that the as been signed by th 2 should be detache	ed by								1 🗆	Yes :	2 □ No 3 □ P	robably 4 Unknown
Records,	ding Physician: The law r. n. After this certificate has be funeral director, page 2 sh	Completed								perl	opsy formed?	prior to death?	utopsy findings available completion of cause of
	ificati		25. Was case referre	ed to medical					26 Place of D	1  Yes eath (Check only	2.4 K	lo 1 □ Yes	2 □ No
or Vital	Physician: this certificand director, in	o Be	examiner?	/	Hospital: 1 / Inpati	ent 2 🗆	ER/Outpatie	nt 3 DOA Oth	ner:			6 □Other (Spe	ncifu)
0	Phy er this eral d	: To	27. Manner of Death		28a. Date of Inju	ıry	28b. Time o			28d. Describe			icny/
o	ding h. Afte	tior	1 ☑Natural 2 ☐ Accident	5 Pending investiga	(Month, Da	y Year)	Injury		rk? ]Yes 2∐No				
Division	l or Attending after death. Director: After	fica	3 ☐ Suicide	6 ☐ Could no determin	20e. Flace of Iti	ury - At ho	me, farm, st	eet, factory, office					ural Route Number,
Ö	after after Dire	Certification:	4 ☐ Homicide	dotoiiiii	building, e	tc. (Specit)	()			City or To	own, Sta	te)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the				Physician: To the best xaminer: On the basis	of examina							
	<b>To the</b> within 2 <b>To the</b> complet	Medical	29b. Signature and	title of certifie	and manner si	aleu.		29c. Licens	se number		29d. D	ate signed (Mon	th, Day, Year)
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K	<u>LU</u>		30. Name and addr	ss of person-u	no completed cause of	death (Item	23a) (Type,	Print 328	Southe	m Ave	SE	WDC	
	Sta Regist		31. Date filed (Monti	h, Day, Year) 9 2007	32. Regist	rar's Signa	ad)						
			JUL 9		A CONTRACTOR OF THE PARTY OF TH	//							

			For State Registrar	State of Ma	rylaliu / i		tificate of l			Reg. N	2007	23727	
÷	Division		1. Decedent's Name (First, Middle, Last	")					2. Date of Month		Day Year	3. Time of Death	
þ	Physicia /Medic	_	EDDIE M. CO	)BB					JULY		2007 4c. County of Deat	7:30A <sup>M</sup>	
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or			4			
1 kg			3410 24th AVENUE		(In yrs. last bi	rthohu)	HILL CI	REST HEI		Birth	PRINCE GEORGE'S  Birth Day, Year)  9. Birthplace (State or F Country)  Country)		
	Funeral Director			ЛМ ОПЕ	81	Yrs.	Months Days	Hours Mir	JULY	16 1	925 ALA	BAMA	
	land bw		10a. State 10b. County		10c. City, Tow							10d. Inside City Limits	
	Mary -f sho fied a	to	MD PRINCE O	SEORGE'S	HILL	CRE	EST HEIGH	ITS				1 X Yes 2 ☐ No	
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Co	ountry?	
	th wit		3410 24th AVENU	JE			20743			U.	S.A.		
	tems term	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes o erto Rican, etc.	r No- )	14. Race - Ame Black, Whit		
900	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show artic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ X Married 3 ☐ Widowed 4 ☐ Divorced	1 □XYes 2 □ N If Yes, Give Year or Dates:			☐ Yes 2 <mark>M</mark> No					BLACK	
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12	withir ene. <b>than</b> <b>h.</b> Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		A TECHNI				GOVERNME	ENT	
ი ე	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Mic	ddle, Maio	den Surname)		
an	ld be ental ked c	To Be	JEFFERSON COBB					MAF	RY COM	ER			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7 BERNICE COBB/WI								ty or Town, State, IGHTS , MAF	Zip Code) RYLAND 20743	
ନ୍	f Heal fem 2		20a. Method of Disposition		20b. Place o	of Dispos	sition (Name of natory or other place	ne)	Date	20c	. Location - City or	Town, State	
9	Page ent o nt: If ny or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				TION CEME		7/2007	CL	INTON, MA	RYLAND	
alt:	mit. partm portai  y inju		21. Signature of Funeral Service Licen	see all							IS FUNERA		
m	Depar Depar Impor any ir		1-K.D. H_	hall							, MARYLAN	T	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lir	the death. Do	not ente	er the mode of dyir	ng, such as card	iac or respirate	ory arrest,		Approximate Interval Between Onset and Death	
Va.	Physician		Immediate Cause (Final disease or condition	.aA1	zheimer	's I	)isease						
Partie of	/Medical Examiner		resulting in death)		a consequence PSIS	of):							
		ē	Sequentially list conditions, if any, leading to immediate	b	a consequence	e of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6									
oʻ	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence	e of):							
68760,	ate be nysicia he bu	edical	•	d									
	ng ph		IF FEMALE:					-					
P.O. Box	w requires that the death cert been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal deat	th 3⊑ 5⊑	Ectopic pregnanc Other (s <i>pecify)</i>	у			23d. Date of de Month	Day Year	
	requires that the reen signed by th hould be detache		Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the ur	nderlying cause giv	ven in Part I.	23e.	Did tobace		to the cause of death?	
rds	quires n sigr ıld be	d by								1 ☐ Yes	2 No 3 F	Probably 4 Munknown	
or Vital Records,	law rec as bee 2 shou	Completed								Was an autopsy	24b. Were a	autopsy findings available completion of cause of	
æ	9 <u>c</u> 9	E O							101	performeg	d? death? No 1 ☐ Ye		
ital	hysiclan: Th nis certificate I director, pag	Be C	25. Was case referred to medical examiner?						Death (Check of	only one)			
<u>-</u>	S 0 =	10E	1 ☐ Yes 2 ☐ \$No		ent 2 ER/C		1 3 DOX				e 6 □Other (Sp	ecify)	
n o	ding Phy. h. After thi		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b.	. Time of Injury	Wo	ryat rk? ]Yes 2 ∐ No	28d. Desc	ribe how i	injury occurred		
Sio	Attending r death. ector: After oy the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		ury - At home	farm. str	eet, factory, office	1 tes 2 140	28f. Locat	ion (Stree	at and Number or F	Rural Route Number,	
Division	i E te	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)				City o	r Tòwn, S	State)		
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	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier				29c. Licen	se number		29d.	Date signed (Mor	nth, Day, Year)	
)	F S F O		> Welland	6 Cerus		-	D352	06		JU	JLY 6, 20	007	
	(10)		30. Name and address of person who	completed cause of d	eath (Item 23a	) (Type,	Print)						
12	(10)		LITITAM T TANN	FR M D 11	701 LTV	VING		D # 101	FT. WA	SHING	GTON, MAF	RYLAND 20744	
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DHMH 17 Rev 1/2001

_			Registrar			Cei	rillicate c	ii Deal	71		Reg. No.	CUUI	6016
	Dharaisi		1. Decedent's Name (First, Middle,	_ast)					2	2. Date of De Month	eath Day	/ Year	3. Time of Death
	Physici /Medi		ANNA	М.	COL	Æ				JULY	6	2007	5:10A M
	Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Tow	n, or Locatio	n of Death		4c.	County of Death	
			VILLA ROSA NUR	SING HOME			MIT	CHELLY	VILLE	PRINCE O			ORGE"S
4	Funeral			Sex 7. Age	(In yrs. la	as <i>t birthd</i> ay)	If Under 1 Ye		er 24 Hrs.	B. Date of Bir (Month, Da			place (State or Foreig
	Director		218-32-1491 Usual Residence of Decedent	1□ M 2□N 94	+	Yrs.	Months Da	ys Hours	s Min.	MARC:	H 14		ARYLAND
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. inside City Limits
	Many f sh	ō	MD PRINCE	E GEORGE'S	SPR	INGDA	LE						1 X Yes 2 No
	the I	le CI	10e. Street and Number				10f. Zip Cod	Α			10a Citi	zen of What Cou	intry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Merical Examiner must be notified at	Funeral Director	3806 KEEHAR COU	חיי			2077				_	U.S.A.	
	eath	era	11. Marital Status	12. Was Decedent E	vor in II S	13			Origin? (Speci	fy Voc or No		14. Race - Ameri	can Indian
	lten ner	ä	1 Never Married 2 Married	Armed Forces?		. 10.	Was Decedent of If Yes, specify C	Suban, Mexic	can, Puerto Ri	ican, etc.)		Black, White	
36	rs af ", or camil	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 💢 1	No Speci	ify:		İ	Specify: BL	ACK
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ă	ould be f Mental H arked of atic ever	Be	GEORGE DIGG					10.100	ETHE			Jumamej	
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, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. informant's Name/Relationship VIOLA BRESSA	(Type. Print) NT/NIECE			ng Address (Stre KEEHAR					r Town, State, Zi RYLAND	p Code) 20774
re	oth		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of matory or other	nlace)	Da	te	20c. Lo	cation - City or T	own, State
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic				2. Name and Ad					NS FUNER	
B	Depar Impor any Ir		* K. D. M	1000			7474 LA	NDOVE				MARYLAND	
	Physician /Medical Examiner	)r	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. <u>DEME</u> Due to (or as a	CNTIA conseque	ence of): TO THI	RIVE						Interval Between Onset and Death
ox 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	n/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	2	INS	DISEA	SE						
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Д,	s tha	by P	Part II. Other significant conditions	contributing to death but	not resul	ting in the u	nderlying cause	given in Pa	rt I.	23e. Did	tobacco u	ise contribute to	the cause of death?
g	puires sign	d b								1 🗆	Yes 2]	No 3□ Pro	bably 4 🖯 Unknow
Records,	w require been signature	Completed								04- 14/		1045 1415	
3e	has he 2	m								24a. Was	psy	prior to co	opsy findings available ompletion of cause of
-		Ö								1□ Yes	ormed? 2 No	1 ☐ Yes	2 No
Vital	Physician: The law this certificate has I	Be	25. Was case referred to medical examiner?						ace of Death (	Check only	one)		
Or \	this c	2	1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 🗆 E	R/Outpatier	nt 3□ DOA	Other: 4X	Nursing Home	e 5 ☐ Resi	dence	6 □Other (Speci	ify)
ion	After une		27. Manner of Death  1∑□ Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Injury (Month, Day ion	Year)	28b. Time of Injury	1	njury at Vork? □ Yes 2		d. Describe	how injur	y occurred	
Division	or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At hor (Specify)	ne, farm, str )	eet, factory, offi	ce	28	f. Location ( City or To			ral Route Number,
_	To the Hospital or I within 24 hours after To the Funeral Directorpletely filled in b	Medical Co								and manner as I place, and due	stated. to the cause(s)		
	To the To the Complete	Me	29b. Signature and title of certifier	A			29c. Lic	ense numbe	er		29d. Dat	te signed (Month	, Day, Year)

State Registrar

PETER SCHISSLER M.D. 7500 GREENWAY CENTER DRIVE # 430 GREENBELT, MARYLAND 20770 31. Date filed (Month, Day, Year)

JUL 0 9 2007 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D22780

JULY

6, 2007

#### Jewel Cook 07-04885 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

### Process of Process	side City Limits Yes 2 No
4b. City, Town, or Location of Death 2300 Block Cylburn Avenue  4b. City, Town, or Location of Death 2300 Block Cylburn Avenue  5 Social Security Number 6 Sex 7 Age (in yrs. last birthday) 10 Lisual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. Ci	State or Side City Limits Yes 2 No
2300 Block Cylbum Avenue  Baltimore  Baltimore  Baltimore  Baltimore  S. Social Security Number   6. Sex   7. Age (in yrs. last birthday)   If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY   9. Birthplace (S Foreign Country)   12. May   15. Decedent   10. County   10. City, Town or Location   10. State   10. County   10. City, Town or Location   10. State   10. County   10. Street and Number   10	side City Limits Yes 2 No
Director    Director	side City Limits Yes 2 No
Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  10d. Institute and Number  10f. Zip Code  10g. Citizen of What Country?  10g. City, Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  10g. City Town or Location  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent Ever in U.S.  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent Ever in U.S.  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent Ever in U.S.  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Martial Status  11g. May Decedent Ever in U.S.  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Martial Status  11g. May Decedent Ever in U.S.  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Martial Status  11g. Martial S	Yes 2 No
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With the etc. Specify Cuban, Mexican, Puerto Rican, etc.)  1. Was Decedent 2 of In U.S. Armed Forces?  1. Never Married 2 Married 3 Widowed 4 Divorced of 1928 No 11 Yes 2 No specify:  1. Never Married 2 Married 3 Widowed 4 Divorced of 1928 No 11 Yes 2 No specify:  1. Never Married 2 Married 3 Widowed 4 Divorced of 1928 No 11 Yes 2 No specify:  1. Never Married 2 Married 3 Widowed 4 Divorced of 1928 No 11 Yes 2 No specify:  1. Never Married 2 Married 3 Widowed 4 Divorced of 1928 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 2 No specify:  1. Never Married 2 Married 1 Yes 3 No specify:  1. Never Married 2 Married 1 Yes 3 No specify:  1. Never Married 2 Married 1 Yes 3 No specify:  1. Never Married 2 Married 1 Yes 3 No specify:  1. Never Married 2 Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No specify:  1. Never Married 1 Yes 3 No sp	an, Black, K
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21. Signature of Funeral Septice Vige View 22. Name and Address of Facility Greene Funeral Home  22. Name and Address of Facility Greene Funeral Home  314 Franklin St. Alexandra VA 223  Physician  23a. Part I. Effect the crease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure of the control of	
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Physician  23a. Part I. Ever the crease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. Approximately the control of the contro	
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23d. Date of delivery  23b. Was decedent pregnant in the  1 Live birth  2 Fetal death  3 Ectopic pregnancy  Month  Day	Year
9 je si se se past 12 months?  Pregnant at time of death 5 Other (Specify)	,
On the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause	se of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca	
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autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
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Examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other; Warsing Home 5   Residence 6   Other: Scene	
To be all the properties of th	
Investigation   Jun 27, 2007   0546 hrs   28f. Location (Street and Number or Rural Route	e Number, City
O so the first of	
	( )
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The state of the cause of the ca	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, June 27, 2007	, rear)
30. Name and address of person who completed cause of death (Item 23a)	
Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day Year)  Registrar  32. Registrar's Signature	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month William 12:00 p M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

If Under 1 Year If Under 240/rs. a Date of Birth

Month, Day, Pre Heslth Bell Rehab Center Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1**∑**M 2□F 08/24/1957 Director Yrs. 220-66-9233 Washington DC 49 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No r 28a-f a Maryland Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or than "natural", or Itama 23a or the Medical Examiner must be 6401 Ronald Road 20749 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. iled within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Horse Handler Laurel Race Track traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be permit. Pages 1 and 2 should be 1. Department of Health and Mr important: if item 27 the any injury or reference. 2 William Coates Sr. Thelma R. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry Coates/ Brother Prince Frederick, Maryland 79 Gray Inn Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatjon 5 ☐ Other (Specify) 4 Donation Metropolitian 7/7/07 Alexandria, Virginia 22. Name and Address of Facility Adams Funeral Home PA 21. Sign ture of Funeral Service Licensee 20605 Aquasco Rd. Aquasco, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Physician Ineck car anome head disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2□No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death /Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes → No Hospital: Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation after deeth.

Director: Af
d in by the fur 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b Signature and title of certifier 29d Date signed (Month, Day, Year) 30. Name and order ss of person who complete cause of deat. (Item 23a) (Type, Print) Aue-Kensington MD ), GGS MUS 10400 connecticut 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

in the second	Physiciar /Medica Examine
	Funeral Director

and 2 should be filed within 72 hours after death with the Marylanc r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, t

3altimore, Maryland 21215-0036

**Physician** /Medical Examiner

> burial-tra attending physician for use as the burial

Division or Vital Records, P.O. Box 68760 Hospital or Attending death. To the Hospital of within 24 hours af To the Funeral D 03H-6

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month ROGER 6. 21:04 ta. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHING TON HAGERS TOWN COUNTY HOSPITAL WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 1 ▼M 2 □ F Months Hours 180-38-8580 Jan. 4, 1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d Inside City Limits 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17144 Virginia Ave. Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: <u>ک</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Trailer mechanic Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Dayley ၉ Gladys S. Keefer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine A. Dayley/wife 17144 Virginia Ave., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Welsh Run CH. Cem. 07/13/2007 Mercersburg, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lininger-Fries Funeral Home 21. Signature of Funeral Service Licensee Cllin tues 47 N. Park Ave., Mercersburg, PA 17236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COYONGVU IM Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dia Defec Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ★ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 052327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPAL MEDICAL & ROUP WASEEM, M.D. MUHAMMAD HAEERS TOWN 1126 OPAL COURT. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State of Ma	aryland		artment of F ctificate of		and M	-	_	000		17700
			Registrar  1. Decedent's Name	(First, Middle, Last)			Cei	lilicate of	Dealli		2. Date of De		7.00	3.	Time of Death
	Physici /Medio		CLARA	DEPTULA							Month July	Day		7 1	1:55 <sup>AM</sup>
	Examir		4a. Facility Name (If	not institution, give s	reet and number)			4b. City, Town, o	r Location o	of Death		4c.	County of Dea	ith	++33
			Berlin Nu	rsing & R			ast birthday)	Berlin If Under 1 Year	If Under:	24 Hrs.	8. Date of Bir		Worcest		(State or Foreign
ь	Funeral Director		194-22-924		M OFF	86	Yrs.	Months Days	Hours	Min.	(Month, De 10/1/19	y, Year)		ountry) `	PA
	pu ,		Usual Residence of I	Decedent 10b. County		10c. City	, Town or Lo	cation						10d In	side City Limits
	Maryla f shor	lor	DE	Sussex		Lew									∐Yes 2 MNo
	n 28a	irec	10e. Street and Num					10f. Zip Code				10g. Citi	izen of What C	ountry?	
	ath wit	ral D	2036 Sava	annah Circ				1995				US			
36	be filed within 72 hours after death with the Maryland that Hygiene.  Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Marrie 3 □ Widowed 4	ed 2 Married	<ol> <li>Was Decedent Armed Forces?</li> <li>1 ☐ Yes 2 X</li> <li>If Yes, Give Year or Dates:</li> </ol>			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Orig an, Mexicar Specify:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi Specify: W		
215-0036	2 hour	ted !		15. Decedent's Educ fy only highest grade	ation	Į.	16a. Dece	dent's Usual Occup	ation	t of workin		16b. Ki	ind of Business	/Industry	
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aryland	ould be to Mental larked or atic eve	To Be	Charles I	Hunt					E1i	zabe	th Unk	nown			
láry	2 should be filed wand Mental Hygie Is marked other traumatic event, th		19a. Informant's Nar	me/Relationship (Typ	e. Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rura	l Route Numb	er, City c	or Town, State,	Zip Code	<del>)</del>
e, k	and tealth m 27 her t		Joseph De			20b. Pl		Savannah sition (Name of	Circ		Lewes,		19958 ocation - City o	Town. S	State
TOL	Pages ent of nt: If Its		1 □ Burial 2 □	Cremation 3 □Ro 5 ☑ Other ( <i>Specify</i> )	emoval from State	Ce	emetery, crei	matory or other plac 1 Cemeter	i _ i _	/12/			limingt		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.			neral Service License			22	2. Name and Addre	ss of Facilit	y Th	e Burb	age :	Funera1		
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rds, P.	w requires that been signed b should be deta	by	Part II. Other signifi	cant conditions con	tributing to death b	out not resu	ilting in the u	nderlying cause giv	en in Part I.				use contribute		use of death?
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o	Phys ral di	۲: ا	1 ☐ Yes 2	****	28a. Date of Inju	ıry	ER/Outpatier 28b. Time o	IL 3 L DOA	4		ne 5 Resi		6 □Other (Sp ry occurred	ecify)	
ion	Attending I r death. ector: After by the funer	atior	1 Natural 2 Accident	5 Pending investigation	(Month, Da	ly Year)	Injury		Yes 2	No					
Division	= = = =	Certification:	3∐ Suicide 4 ∏ Hornicide	6 Could not be determined	28e. Place of inj building, et	ury - At ho tc. (Specify	me, farm, str /)	eet, factory, office		2	8f. Location ( City or To	Street ar wn, State	nd Number or F e)	Rural Rou	ite Number,
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	To the within To the complex	Me	29b. Signature and	title of certifier	7		-	29c, Licens	e number				te signed (Mor		
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07-05201 Frederick Davis

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	1-For State Certifica Registrar	te of Death	Reg. No.
Physician/	Decedent's Name (First, Middle,Last)	l M	ate of Death  tonth Day Year  UV 6, 2007  2325 hrs
Medical Examiner	FREDRICK DAVIS  4a. Facility Name (if not institution, give street and number)	Ju 4b. City, Town, or Location of Death	1ly 6, 2007 2325 RFS
1	16426 Pennsbury Road	Bowie	Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	**	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	252 43 5243 1XM 2F 40	Yrs.   Months Days Hours Min. 0	3/19/1967   Country) GA
· · · · · · · · · · · · · · · · · · ·	Usual Residence of Decedent		10d. Inside City Limits
w any	10a. State 10b. County 10c. City, Town of	Cocation	1 Yes 2 X No
daryland 28a-f show 1 -t once. ector	MD PRINCE GEORGES BOWIE  10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
the Maryland to 28a-f sho	16426 PENNSBURY DRIVE	20716	UNITED STATES
s 23a s 23a e notib		13. Was Decedent of Hispanic Origin? (Specify	
r death with  or items 23  must be no  Funeral	1 Never Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rica	
safter crall, on timer in by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: BLACK
hours natur Exam	d	ecedent's Usual Occupation (Give kind of work ouring most of working life. DO NOT use retired)	done 16b. Kind of Business/Industry
36 iin 72 than " dical.	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2 TH  DF	LIVER	UPS
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21215 Mental H Mental H marked c r event, til	(UNKNOWN) EPPS	ALLENÉ D	AVIS
O ₹ 5 5 5 1 .		Mailing Address (Street and Number or Rural	
Z da 2	1101/12(01) 117	22 BARNABY TERRACE SE Disposition (Name of cemetery, Da	
	1 X Burial 2 Cremation 3 Removal from State cremato	ry or other place)	
Baltimore, sernit Pages I ar Department of Her Important: If ite njury or other tr	4 Donation 5 Other Specify: CLARKE		3/2007 CLARKESVILLE, GA
Baltimore permit Pages I Department of I Important: If i	1. Maulel	MARSHALL'S FUNERAL 4308 SULTLAND ROAD	HOME OF MARYLAND, INC. SUITLAND, MD 20746
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac or res	piratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical		lead · · ·	Death
tammer	or condition resulting in death)  Due to (or as a consequence of):		
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cords, P.O.  Iaw requires that the has been signed by 2 should be detach on pletted by P.D.			1 Yes 2 No 3 Probably 4 Unknown
ords w requires been should	25 N. P. H. H.		24a. Was an autopsy prior to completion of cause of
Records, The law requires ficate has been sign, page 2 should be			performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 2 N
certification certification Be C	25. Was case referred to medical examiner?	26.Place of Death (Check only	
Division of Vital Records, P.O., pital or Attending Physician: The law requires that thours after death.  seral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach Certification: To Be Completed by P.	TV Yes Z INO	apations o	The state of the s
nding ading h. After tuner e funer ion:	27. Manner of Death   28a. Date of Injury   28b. T   1   Natural   5   Pending   Jul 6, 200   2315	in it is less	bject shot self
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8 4 5 7	/98 Leniner.		
To the Hos within 24 h. To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.		
AL.	29b. Signature and title of certifier	29c. License number  O.C.M.E.	29d. Date signed (Month, Day, Year)
	was Hallen		July 9, 2007
3	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111	Penn Street, Baltimore, MD 21201	
State	3 No F		
Registra			

		1 - For State Registrar	State of M	arylar				lealth a		R	eg. No.	7	23734
Physicia /Medic Examine	al	1. Decedent's Name (First, Middle, La  Do R 1 S  4a. Facility Name (If not institution, giv	- DAV	115		4b. City	Town, or	Location of		Date of Dea Month 7	Day 7	Year 7 of Death	3. Time of Death A
Funeral Director		Chesapeake Woods 5. Social Security Number 6. S	Center	e (In yrs.	last birthday) Yrs.	CAI	n Biz	If Under 2	2	Date of Birth (Month, Day June 20	1	ches	ter lace (State or Foreign try) Jersey
Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD Dorch	nester	10c. Cit	ty, Town or Lo		Cambi	ridge				1	0d. Inside City Limits 1   Yes 2   No
death with the Maryland	Funeral Director	10e. Street and Number 525 Glenburn Av	enue			10f. Zi	p Code	216	13	1	0g. Citizen of W USA		try?
urs after	۵	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 X If Yes, Give Year or Dates:			Was Dece If Yes, spe 1 Yes		ispanic Origi in, Mexican, Specify:	in? (Speci Puerto Ri	ty Yes or No- can, etc.)	Blac	e - Americ k, White, whi	etc.
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partill force, Mar permit. Pages 1 end 2 shu Depertment of Health and Important: If them 27 Is meny injury or other treum once.		Patricia Moore  20a. Method of Disposition  1XI Burial 2 Cremation 3 4 Donation 5 Other (Specif	daughte	20b. F	3771 Place of Disposemetery, createry, createry	Wink Distion (Na Thatory or Vete: 2. Name a	ler A me of other place rans nd Addres	Ave. E Cem.	7/12/ Tho	Apt. 61 '07	8, Ft. 20c. Location - Hurloc neral H	Myer: City or To	s, FL 33916 wn, State
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely fi	Certification:	3 Suicide 6 Could not b	e 28e. Place of Inj building, et	c. (Specil	<b>(y</b> )					City or Town	n, State)		I Route Number,
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F > F 0		30. Name ddress of person who		leath (Item	n 23a) (Type,	Print)	H	005	997	73	7/101 idge,	107	0
Stat Registra		31. Date filed (Month, Day, Year)	7007 32. R. Str	ar's Signa	ature	Soul	ove 30	Sr,	a	MOR	inge,		<u> </u>

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Tilly 2001 Abraham Dancil /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Doctor's Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 MM 2 F 1, 90 Director 264-18-5434 Nov. 1916 Florida Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director Prince George's Maryland Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 23a 7424 Drumlea Road 20743 must United States Funeral r than "natural", or Items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black. <u>م</u> 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th Laborer Private is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barsley Dancil Susie Gibson P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Pages 1 and 2 7424 Drumlea Rd., Capitol Heights, MD 20743 Bettie D. Taylor/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Magazian 2 ☐ Cremation 3 ☐ Removal from State 7/13/2007 Royal Palm Cemetery St. Petersburg, FL 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen a 22. Name and Address of Facility Stewart Funeral Home Wash., DC 20019 4001 Benning Rd., NE rocul 23a. Part1. Ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on our line. Approximate Interval Betw Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions Examine al failure cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Tes 2X No 2 ER/Outpatient 3 DOA 1 Xinpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide Medical 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of 29c. License number MDO 58446

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar
DHMH 17 Rev 1/2001

State

Name and add

31. Date filed (Month, Day,

ss of person who completed cause of death (frem 23a) (Type, Print)

			For State Registrar		State of Ma	aryland / De	epartme Certifica	ent of H	lealth and l Death	Mental H	ygiene Reg. No		The state of the s	23736
	Physici	-5.	1. Decedent's Na	ame (First, Middle,						2. Date of D Month	eath Day	y	Year	3. Time of Death
	Physici /Medic		JOHN	ABIJAH	DAVIS					Ju1y		007		11:30 a <sup>M</sup>
ř.	Examin	er			give street and number)		4b. Ci	ty, Town, or	Location of Deat	h		County o		
			6016 F 5. Social Security	Kilmer St		e (In yrs. last birtho		ever1	y If Under 24 Hrs	8. Date of B				lace (State or Foreign
	Funeral Director		079-09-		1 <b>∑</b> M 2□ F	100 Yr	Month		Hours Min.	01-04	Day, Year)		Coun	lace (State or Foreign itry)
			Usual Residence								_1307			
	how	L	10a. State	10b. County		10c. City, Town o	r Location						1	0d. Inside City Limits
	Ba-f	cto	Maryland		George's	Chever					1			1 X Yes 2 No
	dith th	Directo	10e. Street and i					Zip Code				izen of W	hat Coun	itry?
	e 23g	eral		Kilmer St	reet 12. Was Decedent I	Ever in 11 S		20785		nacify Vas or N	U.S		- Americ	an Indian,
	ter de	Funeral	11. Marital Statu 1 □ Never M	s arried 2□ Marrie	Armed Forces?		If Yes, s	pecify Cuba	ispanic Origin? (S an, Mexican, Puer	n Rican, etc.)			c, White,	
936	urs af	by	_	d 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>X</b> No	Specify:			Specify:	Whi	te
Š	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or iteme 23a or 28a-f ehow event, the Modinal Examiner must be codified at	Completed	(9)	15. Decedent's pecify only highest		16a. D	ecedent's U	sual Occupa	ation	rkina	16b. K	ind of Bu	siness/Ind	dustry
2	ithin in ith	nple		econdary (0-12)	College (1-4or 5	i+)	te. DO NO	Tuse retired	during most of wo	9				
2	filed w Hygien other th				04	70	mer		40 14-41 - 1- 11-	- Affirm Addition				<u>ls Furniture</u>
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Maryland 21215-0036	permit. Pages 1 and 2 should be f Department of Health and Mental is Important: If Item 27 Ie marked of eny injury or other traumatic eve any injury or other traumatic eve	스		n Alley D Name/Relationshi		19h A	failing Addr	nce (Stroot	Agnes  and Number or Re	Crowley		or Town 5	State Zin	(Code)
Ma	and 2 sealth an m 27 leinher traui				Grandson				Street,		50.1			
	Heal Heal tem S		20a. Method of I		Grandson	20b. Place of Cometery,				Date				own, State
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Baltimore,	permit. P Departm Importar eny injur			Fundral Service Li		bt. rat			ss of Facility					ore Ave.
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Box	es that the death certifica igned by the attending ph be detached for use as th	ian/M	IF FEMALE: 23b. Was deced		23c. If yes, outcome	of pregnancy 2  Fetal death	3 □Ectopic	c pregnancy	,			23d. Date		*
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Š,	The law requires that the death certificate be executed to be seconted to be been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	ρ	Part II, Other sig	Jillicant condition	s contributing to death b	at not resulting in t	ne underlyin	ig cause giv	enin ranti.		Yes 2			pably 4 Unknown
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<u></u>	yslcian: The is certificate hi director, page		05 111	eferred to medical						1 Yes			☐ Yes	2 No
5	slcia s certi	o Be	examiner?		Hospital: 1 ☐ Inpatie	ent 2 ER/Outp	ationt 3	DOA Oth	26. Place of De	ath <i>(Check onl</i> Home 5 <b>⊠</b> Re		6 □Othe	or /Specif	5/1
o	Attending Physician: r death. ector: After this certifice by the funeral director, p	n; To	27. Manner of D		28a. Date of Inju	ry 28b. Tir	ne of	28c. Injun		28d. Describ				37
0	nding lath. r: After e funer	atio	1 XNatural 2 ☐ Accider	5 ☐ Pending investiga		y rear) inj	Jry M		Yes 2□No					
Division of Vital Records,	er de recto	Certification;	3 ☐ Suicide 4 ☐ Homicid		ed 289. Place of inj	ury - At home, fam c. (Specify)	n, street, fac	tory, office			(Street ar		er or Rura	al Route Number,
Ō	ital or irs afte ral Dir led in													
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)		Physician: To the best xaminer: On the basis o and manner sta	f examination and/								
	To the within 2 To the complet	Me	29b. Signature a	and title of certifier	1	0		29c. Licens	e number		29d. Da	ite signed	(Month,	Day, Year)
	->-0			Much	ul Be	rand		D	2628	7	J	July	11,	2007
	15)		30. Name and a	ddress of person w	no completed cause of d	leath (Item 23a) (T	ype, Print)		***************************************		1			
_	9			1 Berard		Baltimor	e Ave	., #10	07, Coll	ege Par	k, MI	207	40	
Ę.	Sta Regista		31. Date filed (A	1"1°2007	32. Registr	ar's Signay re	مدا							

				State of Maryland / Department of For Certificate of			iene	7 23737
				Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Deat	th	3. Time of Death
	в	Physicia	an			Month July	8, 2007	0050 M
	1	/Medic		Lane Henry Evans, Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, C	or Location of Death		4c. County of D	
	1	Examin	er	va. I donly reality in not monatory give the experience of	de Grace		Har	ford
				Harford Memorial Hospital Havre  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9.	Birthplace (State or Foreign Country)
		Funeral Director		216-24-9816 1 M 2 F 79 Yrs. Months Days	Hours Min.	(Month, Day, May 29,	1928	Maryland
			1	Usual Residence of Decedent		1		
		/land		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
		Man	to	Maryland Harford Aber	deen			1⊈Yes 2 □ No
		r 28g	<u>le</u>	10e. Street and Number 10f. Zip Code		1	0g. Citizen of Wha	t Country?
		death with the Maryland me 23a or 28a-f ehow rnust ke notified at	<u>Β</u>	38 Raymond Avenue 21	1001			S.A.
		deat	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No- to Rican, etc.)	14. Race - A Black, V	merican Indian, Vhite, etc.
	9	after or ite		1 Never Married 2 Married 1 Never Married 2 No 1 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No			Specify:	White
10	8	ral',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1948-52				
3	21215-0036	within 72 hours after ene. than "natural", or Ite ne Medical Exemina	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Dccu (Give kind of work done life. DO NOT use retire	ipation e during most of wor	rking	16b. Kind of Busin Aberdeen	Proving Ground
3	121	han ne	m m	Elementary/Secondary (0-12) College (1-4or 5+) Eleven Years Civilian		Z		Maryland
8	2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)		me (First, Middle,		
	anc	ntal H	Be	Oscar Roy Evans		· ·	oeth Eber	le
	<u>~</u>	should nd Men marke umatic	ဥ	19a, Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stree	at and Number or Ri			
1	Maryland	d 2 s th an 7 is 1		A. Nell Evans (wife) 38 Raymond Av				21001
0	بة	1 an Heal em 2		20a. Method of Disposition 20b. Place of Disposition (Name of		Date	20c. Location - City	y or Town, State
No	ğ	nt of it if it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	0.7	/13/07	Wast Chasts	er, Pennsylvania
7/8/	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other traumatic event, Its Medical Examinat must be notified at ance.		4 □ Donation 5 □ Other (Specify) R.A. Ferris & Co., In  21. Signature of Funeral Service Licensee 22. Name and Addr	ress of Facility			
	Ba	Depa Impo eny l		Lee A. Pa Perryvill	tterson 8	Son Fun	eral Home 3-0766	e, P.A.
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.	ing, such as cardia	c or respiratory ari		Approximate Interval Between
				shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	0	-11	-	Onset and Death
	j.	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	Pancr	261111	5	
		Examiner						
			ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
		uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury				
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	89	ifficat g ph) as th	ed					
	Вох 68	n cert andin use	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	icv		23d. Date o	
		that the death cer ed by the attendir detached for use	ic la	in the past 12 months?  1  Yes 2 No  4 Pregnant at time of death 5 Other (specify)			Month	Day Year
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0500	ğ	v requires been sign should be		Multiorgan tailure,		1 U Y	res 2 0 16 3	Probably 4 Unknown
2	Records,	a SC	P E	SOURCE CARDID murreathy		24a. Was autop	osy	re autopsy findings available r to completion of cause of
	æ	tending Physician: The leath. tor: After this certificate ha the funeral director, page	Completed				rmed? dea 2₽No 1□	th? Yes 20 Ho
0	Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		eath (Check only o	ne)	
2	of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Patient 2 ☐ ER/Outpatient 3 ☐ DOA ☐			dence 6 Other	(Specify)
2		ing Pt	Ë	27. Manny of Death 28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury 28c. Injury		28d. Describe h	now injury occurred	
5	Sio	Attending r death.	Sati	Accident investigation M	Yes 2 No			0 (0 10 10 10
22	Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	e	28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route Number,
Evans,		urs af					(-)	ar an elated
200		To the Hospital or Aleminia 24 hours after of To the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my	y opinion, death occ	curred at the time,	date and place, and	d due to the cause(s)
		To the vithin 2 To the complet	Med	one) and manner stated.  29b. Signature and title of certifier 29c. Lice	ense number		29d. Date signed (	Month, Day, Year)
		Vith To Con		man mill	)IC+Do		Talia	2202
	^			30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	17783		300,00	7 -007
1	X	41VA		Mount and additional wife completed causes and additional subject of the subject	an Au	rest:	Abanto.	on Manha
l)		St	ate	31: Date filed (Month, Day, Year) 32. Registrar's Signature		/	1.100.66	, , , you
		Regist		31. Date filed (Month, Day, Year)  JUL 1 0 2007  Level Signature				

			For State Registrar	State of Marylar		artmer rtificat			nd Me		ene g. No.2	07	23	730
	Dhusisi		1. Decedent's Name (First, Middle, Last)						2	. Date of Death Month	Dav	Year	3. Time o	
	Physici /Medio		Norma Lee Elliott							July		007	3:47	A M
-	Examir		4a. Facility Name (If not institution, give s	treet and number)				Location of	Death		4c. County			
			6109 Eldorado Road	7 Ame (In use	lo at histhele u		odesc r 1 Year	Iale If Under 2	4 Hrs o	. Date of Birth	Dorcl			or Foreign
	Funeral Director		214-36-7243	7. Age (In yrs. 69	Yrs.	Months		Hours	Min.	(Month, Day,	1938	Mar	place (State only) yland	
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation							10d. Inside C	ity Limits
Ç	se Maryl 8s-f eho	Funeral Director	Maryland Dorchest	er	Rhode									2 🛚 No
7	vih t	를 등	10e. Street and Number			10f. Zi	p Code	1650		10	ng. Citizen of N US2		intry?	
3	8 23g	rai	6109 Eldorado Road	2. Was Decedent Ever in U	18 13	Was Dags		21659	in? (Speci	fy Vas or No-			ican Indian,	
36 0	s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural, or items 23s or 28s-f show other treumetic event, the Madical Exemplar paral be notified at	by Fun	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, spe		Specify:	Puerto Ri	fy Yes or No- can, etc.)		ck, White		
ð	2 hou	ed	15. Decedent's Educ		16a. Dece	dent's Usu	al Occupa	ation	-f d	1	6b. Kind of B	usiness/li	ndustry	
21215-0036	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life.	DO NOT L	use retired	furing most	at working					
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Ž	Health and tom 27 is my sther treum		19a. Informant's Name/Relationship (Typ. P. Frances Todd/Da			•	,			Route Number. odesda1	-			
Baltimore,	Pages 1 e	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	Place of Dispo cemetery, cre inghill	matory`or	other plac		Dat 12/2/		ebron,	-		
altin	permit. Pages Department of Important: If I eny injury or once.		4 □Donation □ Other (Specify)  21. Sign ture of Fureral Service Ligars	· Q						P. O. st New 1			_	
<u> </u>	8258		stenery	file								, MD	21631	
	Physician		23. Part1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the dea a cause on each line.	th. Do not en		ide of dyin	g, such as c	ardiac or i	respiratory arre	st,		Approxima Interval Be Onset and	tween
	/Medical Examiner		resulting in death)	Due to (or as a consec										
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	5 × 5		0											
D. Box	The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic p □ Other (s						ite of deli-	very Day	Year
ds, P.O.	ires that the de signed by the e d be detached t	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the (	underlying	cause giv	en in Part I.			acco use con		the cause of	
Records,	e law requir has been si je 2 should l	Completed								24a. Was ar	/	prior to c	topsy findings	available cause of
<u> </u>	The tage has page	Pon								perform 1 ☐ Yes 2		death? 1 ☐ Yes	2 □ No	
Vital	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?				101		of Death (	Check only one	9)			
<b>o</b>	S S	2	TE THE ZE ING	ospital: 1 Inpatient 2	_			4 🗆 Nur		e 5 Reside			erfy)	
ion	inding Ph ath. r: After th te funeral	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of M	28c. Injur Wor 1 🗆	/at k? Yes 2⊡N		ld. Describe ho	w injury occui	төа		
Division	el or Atte s after de si Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Special	nome, farm, si ify)	treet, facto	ry, office		28	of. Location (Sti City or Town		ber or Ru	ral Route Nut	n <i>ber</i> ,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai (	(Check only one)  (Check only one)  (Check only one)	nicians To the bast of my kn ner: On the basis of examin and manner stated.	owledge dea ation and/or in	nvestigatio	d at the tir en, in my o	ne data and pinion, deat	d place, an h occurred	d due to the ea d at the time, da	tues(e) and T ate and place,	anner as and due	stated to the cause(	(s)
	To th Mithin Fo th	₹ E	29b. Signature and title of certifier			29	9c. Licens	e number		25	9d. Date signe	d (Monti	n, Day, Year)	
			1 6 2 74	ibet			Hoo	1475	・レン		July	94	, 200	7
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	Print)	رد ا	Eden	(shee	. M7	) 21/	72		
Ē	St. Regist	ate	31. Date filed (Month, Day, Year)	mpleted cause of death (Ite  3304 H  32. Registrar's Sign	nature	1	۷.	-	6	+				

			For State Registrar	State of Ma		partment of I <i>ertificate of</i>			giene lea. No. O T	7 0 70
pe.	Physici	00	Decedent's Name (First, Middle, La	st)				2. Date of Dea	-	3. Time of Death
	Physici /Medio	cal	Walter W	tishe		45 O.S. Town	and a self-self Doorth	07	0907	10448 M
	Examir	ier	4a. Facility Name (If not institution, giv	e street and number)	ake	Sali-	or Location of Death	1	4c. County of D	10 M I CO
	Funeral		5. Social Security Number 6. S	2 0 1 1 1	(In yrs. last birthda	Months   Days		8. Date of Birth	9. l	Birthplace (State or Foreign Country)
į,	Director		218-24-4184 Usual Residence of Decedent	IA W ZUF	76 Yrs.			Sept. 1		elaware
	yland now at		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Mar Ba-f sl	Director	MD Wicon	ico	Delmar					1 X Yes 2 No
	with the		10e. Street and Number			10f. Zip Code	_	1	10g. Citizen of What	Country?
	death ms 23	Funeral	103 East Walnut  11. Maritai Status	12. Was Decedent B	ever in U.S.	2187 3. Was Decedent of I If Yes, specify Cub		pecify Yes or No-	U.S.A. 14. Race - A	merican Indian,
٥	after or ite		1 Never Married 2 Married	Armed Forces? 1 XYes 2 N If Yes, Give	lo 1948–	If Yes, specify Cub		o Rican, etc.)	Black, W	/hite, etc.
<b>2-003</b>	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	ed by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	952	cedent's Usual Occu			16b. Kind of Busine	white
<u>.</u>	within 72 ene. than "na he Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	(Gi	ive kind of work done  o. DO NOT use retire	during most of world)	king	Tob. Kind of Busine	ss/moustry
7	filed with Hygiene other than the sent, the	Com	10			Manager	Т		Garment (	Company
and	ntal H ed oth	Be	17. Father's Name (First, Middle, Last Walter William F					ne <i>(First, Middle, i</i> Frances	Maiden Surname)	
5	2 should be and Mental Is marked of aumatic ev	2	19a. Informant's Name/Relationship (		19b. Ma	ailing Address (Street				e, Zip Code)
, Ma	ges 1 and 2 should be filed within 72 hours after death with the Marylar tt of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		William Edward F	isher (S	on) 109	E. Walnu	t St. De	lmar, MI	21875	
more	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, c	sposition (Name of rematory or other pla			20c. Location - City	
Saltin	그두뿌름		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		St. Step	hens Ceme		12, 2007	Delmar,	Delaware
ñ	Depar Impor any Ir		Eny Shor	t Vew	ell	Short Fun 13 E. Gro	eral Home		ar, DE 19	9940
			23a. Part1. Enter the disease, or com shock, or he failure. List only	plications that caused one cause on each lin	the death. Do not e					Approximate Interval Between
	Physician (Medical		Immediate Cause (Final disease or condition resulting in death)	a. Malis	nent 1	ymphon	~			Onset and Death
	/Medical Examiner		<b>1</b>	Due to (or as a	a consequence of):	. /				
	7 2 2	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of):					1
	ecuter and -transi	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):					
00/00	ificate be executed g physician and as the burial-transit	calE		Due to (or as a	consequence or,					
000	tificate ig phys as the	edi		0.						
X D D	death cert e attending id for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome   1 ☐ Live birth	2 ☐ Fetal death	3 □Ectopic pregnanc	cy		23d. Date of Month	delivery Day Year
	the dea	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify) _			MONTH	Day
7.	The law requires that the ate has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
ecords,	equire en sig ould b							1 □ Y	es 2DNo 3⊡	Probably 4 Unknown
ည်	e law r has be e 2 sh	Completed						24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
Vital	n: Th ficate or, pag		25. Was case referred to medical					perfor 1  Yes	28-No 1 1	es 2 No
<u> </u>	ysicla is certi directo	o Be	examiner?	Hospital:	nt 2 ☐ ER/Outpat	ient 3 DOA Oti	ner:	th <i>(Check only on</i> ome 5 ☐ Reside	<i>ne)</i> ence 6 □Other (S	Specify)
0 = 0	Attending Physiclan: If death. ector: After this certific by the funeral director,	on: T	27. Manner Death Natural 5 □ Pending	28a. Date of Injur (Month, Day					ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u> </u>	death.	icati	C Accident investigation 3 Suicide 6 Could not b	e goo Bloom of inju	nv - At home farm	M 1 Street, factory, office	]Yes 2□No	28f Location (S	troot and Number or	Rural Route Number,
2	al or A s after of in b	Certification:	4 ☐ Homicide determined	building, etc		on out, ideasy, amou		City or Town	n, State)	Thurst House Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical Exal	nysician: To the best of miner: On the basis of	of my knowledge, de examination and/or	eath occurred at the ti	ime, date and place opinion, death occu	, and due to the c	ause(s) and manner	r as stated.
	o the lithin 2 the lo the lomplet	Medical	one)  29b. Signature and title of certifier	and manner sta	ted.	29c. Licens			29d. Date signed (Me	
	- 5 - 0		5 dipt	44	M	Δ:	26278		7-9-	.07
(	J 92/3		30. Name and address of person who	.1 .4 // 1	1 1 .		1737	911	411	1867
	Sta	te	31. Date filed (Month, Day, Year)	-	TO3/14	( PO DY	c1733	001154	)MB 21	0
	Registr		JUL 11:	2007	. K	Sacret,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Jime of Death Year 67 **Physician** Fiore Frank John 0300 M Ò /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Facility Name (If not institution, give street and number) SPLISBURY KEGIONAL MEDICAL LENTER Wicomics If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **№** M 2 F 87 551-18-5663 **Director** 2/26/1920 New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show Examiner must be notified at Director 1 X Yes 2 □ No Pennsylvania Dallastown York 10e. Street and Number 10g, Citizen of What Country? 10f. Zin Code 45 E. Howard Street 17313 USA Funeral death items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☑ Yes 2□ No Army/ If Yes, Give Year or Dates: AirCorp 1 Never Married 2 Married or i 1 ☐ Yes 2 No white þ Specify: 3 XWidowed 4 ☐ Divorced 'naturai' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Airlines of Health and Mental Hygi Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa (unknown) Pasqual Fiore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 E. Howard St., Dallastown, PA 17313 Frank D. Fiore/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/6/07 4 Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD eral Service Livery ee Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Papt. Enter the disease, or complications that caused thock, or heart failure. List only one cause on each be eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final HEMMORRHAGE **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28c. Injury at Work? Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0063199 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 1060 614 SHORE DR. SALISBURY MD

State Registrar

31. Date filed (Month, Day, Year) JUL 1 0 2007

EASTER 32 Registrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#3 Per PHY. State of Maryla State Registrar AACO HEALTH DEPT. 7/6/07 CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 5, **Physician** 2007 1:40 A R. Marilyn Foster /Medical 4c. County of Death 1:40AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Greater Laurel Health & Rehab. Laure1 Prince George 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F 055-28-4038 Director 02/02/1934 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mines on 28a-f show once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 √Yes 2 No Directo Maryland Prince George Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3818 Iron Gate Lane 20715 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married American Indian 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker -12-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Vaughn Mary R. Hughes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leslie Foster Mann/Daughter 15105 Dunleigh Drive, Bowie, Maryland 20725 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place Maryland Veterans 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 07/09/2007 | Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Serv 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) abete **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any 1 aury 1 cause Character Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar as a consequence of physiciar Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) should be detached the 9 Unknown 9 🗌 Unknown signed by conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an certificate has 1□ Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 🔲 Inpatient 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar DHMH 17 Rev 1/2001

The law requires that the death certificate be executed

P.0.

or Vital Records,

Division

6 2007

(Check only

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

avr

one)

completed cause of death (Item 23a) (Type, Print 136

strar's Signature

3

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d/ Date signed (Month, Day, Year)

07-05162 Vernon Ford Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month July 6, 2007 Physician/ 0441 hrs Medical Examiner Vernon Robert Ford 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury Peninsula Regional Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** oreign Min Months Days Hours Country) Maryland Director Yrs August 12 213-36-8993 1 X M 2 69 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Yes 2 XNo North East notified at once. Cecil Maryland Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number United States 21901 423 McKinneytown Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. must be Armed Forces? Never Married 2 X Married Yes 2 X No è White Specify: Yes, Give Year 2 X No specify. Yes item 27 is marked other than "natural", of traumatic event, the Medical Examiner Widowed Divorced 5 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+ Elementary/Secondary (0-12) Imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 Pant of Health and Mental Hygiene. Owner Concrete Company Construction 11 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna M. Creswell Alvin Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 423 McKinneytown Road, North East, Maryland 21901 Jean Reed Ford / Wife tment of Health ar rtant; If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition July Baltimore, crematory or other place) Removal from State Burial 2 X Cremation 3 8, 2007 Newark, Delaware  ${ t Mayerdale\_Crematory}$ Other Specify: Donation 5 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funera Servi Licenses 127 South Main Street, North East, Maryland2190 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death /Medical a Multiple Injuries with Complications Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Undertving Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical X AMENDED #28c.perMF.g870. UNPENDED ending physician use as the burial that the death certificate be 23d. Date of delivery Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Month Day Year 23b. Was decedent pregnant in the Fetal death past 12 months' Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by Part II. Other significant conditions Yes 2 ✓ No 3 Probably 4 Unknown þ Atherosclerotic Cardiovascular Disease Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of Diabetes Mellitus autopsy performed? death? certificate has Yes 2 VINC Yes page 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death
To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital: 1 / Inpatient 2 Residence 6 Other: DOA Nursing Home 5 ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jun 11, 2007 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death House fell on subject Certification: 1436 hrs 1 X Yes 2 No Natural Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 26 W. Main Street, Cristfield, MD Suicide determined (Specify) Single Family Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical Examiner on the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 6, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Chief Medical Examiner David Fowler M.D. 31. Date filed (Month) PRV trar's Signature State 200 Registra

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MFND#8perFH7/10/07, brw. MoCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** М Sophie Friedland 2, 2007 Ju1y 5 /Medical р 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Collingswood Nursing and Rehab. Rockville Montgomery 8. Date of Birth (Month, Day, Year 1920 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 K F Director 151-18-2135 86 7 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 299 Hurley Avenue 20850 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3√√Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Elementary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Issidore Shift မ Leina Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Friedland/ Son 12026 Whipoorwill Lane, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Crematory Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute, 1040 Rockville ost 00 Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Congestive Heart Failure resulting in death) /Medical **Examiner** Coronary Artery Disease Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown End Stage Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 nous after death.

neral Director; After this filled in by the funeral di within 24 hours a To the Funeral C ပို

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Anne Wilson, M.D., 14804 Physicians Lane, Suite 221, Rockville, MD 20852 32 Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D523365

29d. Date signed (Month, Day, Year)

July 6, 2007

		For State Registrar	State of Ma	arylan		artmen tificate					giene Reg. No.	007	23745
		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Day	Year	3. Time of Death
Physicia /Medic		Fleming Jose	eph Gross							July	10	2007	1:20 AM M
Examin		4a. Facility Name (If not institution,	-			4b. City,		Location of				County of Death	
		Loyalton Ass:						gerst					on County
Funeral Director		5. Social Security Number 578–46–2277  Usual Residence of Decedent	6. Sex 1 M 2 ☐ F	71	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day Sept	193	5 Wasi	place (State or Foreign intry) nington D.C.
land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Mary -fsh fied	호	Maryland Monto	gomery	5	Silver	Spri	nas						1 ☐ Yes 2X No
h the	Director	10e. Street and Number				10f. Zip					10g. Citiz	en of What Co	untry?
th will	a	8413 Grove St	creet				20	910				U.S.A.	
r dee	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. V	Was Deced f Yes, spec	lent of His	spanic Ori	igin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	- 1	4. Race - Ame Black, White	
portition of the proof of the p	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 14 Yes 2 □ N If Yes, Give Year or Dates:	5-	2U-90	1 □ Yes		Specify:				Specify:	White
72 h	ete	15. Decedent' (Specify only highest			16a. Deced (Give	lent's Usua kind of wor DO NOT us	il Occupa rk done d	ition <i>uring m</i> os	st of worki	ng	16b. Kin	d of Business/I	ndustry
within than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		ick M					Con	structi	on Company
filled Hygical Part, ant,	S C	10 17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Name	(First, Middle,			
ylani ould be Mental marked o	To B	Eugene A. Gros			1					lverta			
d 2 st d 2 st h and 7 ls n traun		19a. Informant's Name/Relationsh Mary B. Kemp	<i>- daughter</i>							Route Numbe			nd 21713
Healt Healt		20a. Method of Disposition	daugneer	20b. PI	ace of Dispo	sition (Nan	ne of	1		ate		ation - City or	
eges ant of Yer of		1 ☐ Burial 2X☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		CE	emetery, cren Lthsbu	natory or o	ther place		7_12	_2007			Maryland
ertme ortan injur		21. Signature of Funeral Service L		Ontil		_		-					eral Home
Per Per Per Per Per Per Per Per Per Per	2000	* Kutten	Zalfaro	7	1.	331 E	aste.	rn Bl	Lvd.	N. Hage	ersto	wn Mary	land 21742
		23a. Part1. Enter the disease, or shock, or heart failure. List of	niy one cause on each lin	ine death ie.	. Do not ent	er the mod	_			r respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician /Medical	k //	Immediate Cause (Final disease or condition resulting in death)	-	ona	_	rtery	D.	seas	e				
Examiner		,	Due to (or as a	a consequ	uentce of):	1							
	-E	Sequentially list conditions,	b. — Dualto (or sele	a roneequ	ianna ofy:								
uted d ansit	Examiner	Sequentially list conditions, if any, leading to investigate cause. Enter Underlying Cause (Disease or injury that initiated events											
exec an an		resulting in death) Last	Due to (or as a	a consequ	ence of):								
ysicie	icai		d.										
op ph as #	Med	IS ESMALE.											
th ce tendii	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth			Ectopic pr	egnancy				23	3d. Date of deli	
the at	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of de	eath 5□	Other (sp	ecity)					Month	Day Year
d by		Part II. Other significant condition	se contributing to death by	it not recu	ulting in the u	adarhina a	auca awa	n in Dart I		23a Did to	ahacco us	a contribute to	the cause of death?
uires ti	d by	Tall in Other significant condition	is contributing to death bu	21 1101 1430	inting in the di	idenying G	ause give	III NI FOLILI	,				bably 4 Munknown
k req	Completed									24a. Was	an	24h Ware au	opsy findings available
he lay	ш									autop		prior to death?	ompletion of cause of
ificete	ပို	25. Was case referred to medical						00 Diago	( D+b	1 ☐ Yes	1200	1 🗆 Yes	2□ No
/sicie	o B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 🗀 I	ER/Outpatien	t 3[] DO	Othe	_		i <i> Check only o</i> ne 5∐Resid		Cother (Spec	uhe)
ding Physician: The I h. After this certificate he funeral director, page	L'a	27. Manner of Death	28a. Date of Injur		28b. Time of		8c. Injury Work			28d. Describe h			ny)
ath.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	( rear)	Injury	м		es 2 🗆	No				
after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		ry - At ho c. (Specify	me, farm, str	eet, factory	, office		2	28f. Location (S City or Tow		Number or Ru	ral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Yet hours after death.  Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical C	29a. Certifier (Check only one) Continue 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred vestigation,	at the tim	e, date an inion, dea	nd place, a	and due to the o	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
o the ithin i	Me	29b. Signature and title of certifier	and marrier sta			290	. License	number			29d. Date	signed (Monti	, Day, Year)
18		MM)4	MO				Do	058	3726				
1+1		30. Name and address of person v	the completed cause of de	eath (Item	23a) (Type,	Print)	cie (	OT.	ΛΙ.	ersville	ika v	217	177
Sta		31. Date filed (Month, Day, Year)	Ven MD  32. Registra	r's Signat	ture	venty	16	- 1.	11/1	erslike	INCK	, 41	13
Registr	ar	JUL 13	2007 Jenes	0 1	9. Sp	we	Ü.						

		1 - For State Registrar		ryland / Dep Co	ertificate of		Reg	. No.	23/4
Physicia	an	Decedent's Name (First, Middle, Las	<i>t</i> )				2. Oate of Death Month	Day Yeer	3. Time of Death
/Medic	cal	Mary Agnes Gary	attack and aumbarl		4h City Town	and another of Donath	7 10	2007 4c. County of Deat	11:13 A
Examin	ier	4a. Facility Name (If not institution, give Atlantic General			Berli	or Location of Death		Worceste	
Funeral		5. Social Security Number 6. Se		(In yrs. last birthda			8. Date of Birth		
Funeral Director			CIM OFF	02 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) 1/18/190	ear) Co	hplace (State or For untry) MD
D.		Usual Residence of Decedent							
arylar how	-	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Lin
Ba-f o	Director	DE Sussex		Lewes					1 □ Yes 2 🖸
with ti	E E	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
death with the Maryland ma 23a or 28a-f ehow rmat be notified at	Funeral	22748 Hollyway W	12. Was Decedent E	ver in IIS 13	19958		acity Yes or No-	USA 14. Race - Ame	ocan Indian
fter d	E	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	0	If Yes, specify Cut	Hispanic Origin? (Spo ban, Mexican, Puerto	Rican, etc.)	Black, White	
within 72 hours after ene. than "natural", or Ita he Madical Examine	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No	Specify:		Specify: W	hite
2 ho	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dec	cedent's Usual Occu	ipation	16	b. Kind of Business/	industry
thin /	nple	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use retire	during most of work ed)	iiig		
filed wi Hygien ther th	Completed	8		Rec	eptionist	1		Dental S	choo1
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
Men Marke Marke	٩	John THomas Free					Kaufman		
s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelin and Mental Hygiene. I fleeling the marked other than "natural", or Itema 23a or 28a-f ehow tem 21a marked other than "natural" or Itema 12a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (7		i i		t and Number or Rura		•	(ip Code)
Heeltl Fin 27 Ther 1		Charles Thomas G. 20a. Method of Disposition	ary			way West,		c. Location - City or	Town State
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		12 Burial 2 Cremation 3			position (Name of rematory or other pla				
rtant		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licent			Cemetery	ess of Facility Th		altimore,	
permit. Pages 1 and 2 Department of Heelth a Important: If item 27 is any injury or other trai		21, Signature of Furieral Service Licent	and one			Lam St., B	_		Home
		23a. Part. Enter the disease, or comp	plications that caused to	the death. Do not e					Approximate
nysician Medical xaminer		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Cere	brovasu consequence of):		ident			Interval 8 etwee Onset and Deal
physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):		Pulmon	ary Disa	ease	
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The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as th	Completed						24a. Was an autopsy performe	prior to d	topsy findings avail completion of cause
ician: The certificate hi rector, page		05 11/2					1□ Yes 2€		2□ No
ttending Phyaician: death. :tor: After this certifice the funeral director.	) Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:			her	Check only one		
r this	2	27. Manner of Death	1 Inpatien 28a. Date of Injury	28b. Time	ent 3 DUA	4 LI Nursing Ho	me 5 Hesideno 28d. Describe how	e 6 □Other (Speciniury occurred	cify)
th.: After s funera	ij	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		ork? ]Yes 2 □No			
s efter death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, s (Specify)	street, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru State)	ral Route Number
uner uner	edicai	29a Certifier 1 Critiving Phyone 2 Medical Exam	reinian. To the best of iner: On the basis of e and manner state	examination and/or	ath consined at the t investigation, in my	inte, date and place, opinion, death occurr	and due to the dauged at the time, date	and place, and due	stated. to the cause(s)
vithin 2. To the complet	ž	29b. Signature and title of certifier			29c. Licen	se number	29d.	Date signed (Month	n, Day, Year)
		CXX STANN	m6 MD	Attendo	ns D	56312	10	July 200	7 1145
			12		- 1				
BAQ		30. Name and addless of person who o	completed cause of de-	ath (Item 23a) (Type		nué Ber			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23, pt II, 25 per me, 2870, 08/17/07dhb

Reg. No. 1 - For A State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Year Dec sel 2007 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 18, 1962 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Min. Days Hours 1**X** M 2□ F Country) Maryland 45 221-50-7889 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any highry or other traumatic events ones. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Kent Worton 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21678 IISA 24307 Lambs Meadow Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 21 No Specify: þ Specify 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0-Store Owner Glass Company 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Silver Joseph Gsell, Jr. Marie Pritz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11143 Old Worton Road, Worton, MD 21678 19a. Informant's Name/Relationship (Type. Print) Kim Cochran/ sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 14, 2007 Chestertown, MD Chester Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Fellows, Melfembein & Newnam Funeral Home, P.A. 30 Speer Road, Chestertown, MD 21620 Janes of 23a, art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician COLUMNS andiovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-trar to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) ed by the a detached t 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Asthma 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 s autopsy perform certificate 2 No 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA **V** 1 

Inpatient 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) 5 Pending investigation within 24 hours alter conditions To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 27. S. Greene St. Boeltimore MD University of

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

on s

32. Registrar's S

			1 - For State Registrar			artment of F		Mental Hygie	611111	23740		
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of Death		
	/Medic		GEORGE W,			4 60 7	1		4c. County of Deat	12:10 A M		
	Examin	ner	4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Dea	ath	PRINCE GE			
	-		4027 EMERALD LANE 5. Social Security Number 6. S		(In yrs. last birthday)	BOWIE  If Under 1 Year	If Under 24 Hi	s. 8. Date of Birth		hnlace (State or Foreign		
	Funeral Director			XM 20F 59		Months Days	Hours Mi	s. 8. Date of Birth (Month, Day Yo 2-24-48	WASE	DC		
	P.		Usual Residence of Decedent		10a City Town as l					10d. Inside City Limits		
	arylar shov	'n	10a. State 10b. County	EODCE	10c. City, Town or Le					11√2 Yes 2 No		
	he M	Director	MD PRINCE G	EURGE	UPPER MA	10f. Zip Code		100	. Citizen of What Co			
	with the or the		9602 SHUTTLE COUR	т морти		20772			J.S.A.			
	Jeath Ins 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame			
0	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23e or 28e-f show avant, the Moulcal Examinar must be notified at	Fur	Armed Forces?  1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No If Yes, Give				an, Mexican, Pue Specify:	erto Rican, etc.)				
o-00-c	ral', c	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:		1 ☐ Yes 2 🔀 No	эрвспу.			BLACK		
ה	72 h "netu	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occup	during most of w	orking 16	b. Kind of Business/	Industry		
7	e filed within al Hygiene. I other than " vant, tre "	Completed	Elementary/Secondary (0-12) 1OTH GRADE	College (1-4or 5	+)	DO NOT use retired TRUCK DRI		т	RUCKING O	'n		
7 00	filed Hygie ther		17. Father's Name (First, Middle, Last)		10W	INUCK DILI		ame (First, Middle, Ma				
	lid be fental rked c	To Be						LA MYERS	MYERS			
ary	shou and M umet		19a. Informant's Name/Relationship (	Гуре, Print)	19b. Maili	ing Address (Street	and Number or i	Rural Route Number, C	ity or Town, State, 2	Zip Code)		
Ξ	and 2 naith a n 27 i		ERNESTINE G. MOTE	N - SISTER		_		ORTH-UPPER	MARLBORO,	MD 20772		
ore	of He of He fiten		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		osition (Name of matory or other place			c. Location - City or			
Ě	Pag ment tent:		`4 ☐ Donation 5 ☐ Other (Specify	")	1	MEMO. PAR			NDOVER, M			
Бантто	permit. Pages 1 and 2 should be Department of Heath and Menta Importent: If item 27 Is marked eny injury or other treumetic av <u>pnce</u> .		21. Signature of Funeral Service Licen	500 (1) h				INCKNEY-SPA		Н.		
-			23a. Part1. Enter the disease, or com-	plications that caused				E. WASH.,		Approximate Interval Between		
	death certificate be executed  Medical  Examiner  A for use as the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. LUNG CANCER  Due to (or as a consequence of):									
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Clesses of Ir july that initiated events resulting in death) Last				<u> </u>					
09/90		cal	d.									
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 (	□Ectopic pregnancy □ Other (specify) _	<i>f</i>		23d. Date of del Month	livery Day Year		
cords, r	iaw requires that the de as been signed by the 2 should be detached	by	Pate it. Other significant conditions contributing to death out not resulting in the underlying cause				g cause given in Part I. 23e. Did toba		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
000	aw re	Completed						24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of		
r	Ф <del>с</del> Ф	E						performe				
	or Attanding Physicien: after death. Director: After this certific in by the funeral director,	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only one)				
> IO		10	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie			4 🗆 Nursing	ng Home 5 ☐ Residence 6 XOther (SpecifyResidence				
SION		Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be									
=			4 Homicide determined building, etc. (Specify)				City or Town, S					
	수 수 교 수 등	edical	(Check only 2 Medical Exam	niner: On the basis of and manner sta	examination and/or in	in occurred at the till rivestigation, in my o	me, date and pla opinion, death oc	ce, and due to the cause curred at the time, date	and place, and due	e to the cause(s)		
	To the h within 2 To the f complete	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (N									
^	T		In and a	Weras,	M. 1)	4.0	20459	0	7 /06/	2007		
1	9		30. Name and address of person who ANTHONY ARCENAS,		eath (Item 23a) (Type RVING ST		. W. V	WASH., DC	20422			
P	Sta		31. Date filed (Month, Day, Year).	32. Registra	ir's Signature	e j	-					

The law requires that the death certificate be executed attending physician and for use as the burial-trar page 2 should To the Hospital or Attending Physician: director,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0071 2. Date of Death 1. Decedent's Name (First, Middle, Last) See of 3. Time of Death Month Year Physician July 6, 2007 1:30 A Gefter Nadezhda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 30, 1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2X F 96 Azerbaijan 377-15-8152 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County X Yes 2 No Gaithersburg Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 20877 United States 17060 King James Way #605 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Piano Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Markowich Saveliy Kolmanovsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12823 Tern Drive North Potomac MD 20878 Muse Aliyen - Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 07/08/07 Olney, MD Judean Mem. Grdns 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 21. Signature of Euneral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUPSIS disease or condition resulting in death) days Due to (or as a consequence of): tract infection Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier acra J. Mistry 1259738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, MD 20850 Alicia T. Mistry 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 1 0 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 06:15 <sup>A M</sup> Ju1y 8 2007 Gritzman Μ. Murray /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Montgomery Hospice, Casey House 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1**X** M 2 □ F Days Hours Months 1926 New York Director 112-20-3786 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner misst he martified of 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 ☐ No Director Rockville MD. Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 U.S.A. Funeral Apt #727 10201 GROSVENOR PLACE 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Jewelry Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zelda Friedman ဥ <u>Meyer Gritzman</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10201Grosvenor Place #727 Rockville MD. 20852 Lorraine Gritzman - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition The Burial 2 Cremation 3 Anemoval from State 4 Donation 5 Other (Specify) Centre County Mem.Pk July 11,2007 State College , PA 21. Signature of Funeral Service Licensee Edward Segel Funeral Direction INC. 1091 Rockville Pike Rockville MD, 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Cell Carcinoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【※No 24a. Was an autopsy 1☐ Yes 2 💢 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{6}\square$  ther (SpecifyHospice 1 ∐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064615

Registrar

State

DŔ.

31. Date filed (Month, Day, Year)

JUL

6001 Muncaster Mill Road Rockville MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Geneveive Wroblewski,

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** рМ /Medical Dorothy Gunsalus 2007 July 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7905 Ivymount Terrace Potomac Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 25 MF Director 529-40-2373 March 19,1928 Washington, Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at District of N/A Washington 1 Yes 2 No Director Columbia the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2210 Sudbury Road, NW permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must Jonce. 20012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Alfonso DiBattista Mary Margaret Douglas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7905 Ivymount Terrace, Potomac, MD 20854 Patrick J. McEvoy/Brother-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 d Burial 2 ☐ Cremation 3 ☐ Removal from State 11, July Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring. 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Generalized Carcinomatosis Months /Medical Due to (or as a consequence of): **Examiner** Primary Cancer of the Liver Sequentially list conditions, if any, iscanng to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6\_Months Days to for as a consequence off Examine The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🔀 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Cirrhosis of the Liver 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 1 Yes 2 🙀 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6x30ther (Specify) residence Brother-in-law's 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 X Natural 5 Pending Injury To the mosping within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 15C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Meill Kennedy,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

5530 Wisconsin Avenue, Chevy Chase, Md 20815 Registrar's Signature

D13187

July 9, 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Tiogistial		tificate of I		,	Reg. No.	11:1/	237	52
Physician /Medical			1. Decedent's Name (First, Middle, Last)  Walter Calvin	2. Date of I Month 07			Day 06	Year 07	3. Time of 1058	Death M	
Examine			4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. Co	ounty of Death		
No.			WMHS Braddock Campus		Cumber				11egany		
20	Funeral Director		210-30-1931	Yrs.	If Under 1 Year Months Days	(Month, Da	(Month, Day, Year)		Birthplace <i>(St</i> ate o <i>r Foreign</i> Country) aryland		
	and		Usual Residence of Decedent  10a, State								y Limits
	Maryl f sho	ō	MD Allegany	Cı	umberlan	d				1 □Yes	2 <b>J</b> -No
	the 28a-	Director	10e. Street and Number		10f. Zip Code	***		10g. Citize	n of What Cour	itry?	
0036	h with										
	deat ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	If Yes, specify Cuban, Mexican, Puerro Rican, etc.)    1 □ Yes 2 □ No Specify:				)- 14	. Race - Americ Black, White,		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 ☑ Married 1 ② Yes 2 □ No1 953 — If Yes, Give Year or Dates: 1955					Specify: White			
ဂ ဂ	72 hc 'natu	etec	15. Decedent's Education 16a. (Specify only highest grade completed)	ent's Usual Occup	t's Usual Occupation d of work done during most of working NOT use retired)			b. Kind of Business/Industry			
N	within jene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		<i>o not use retirec</i> est Ward			State	Corren	om on t	
Z	e filed wall Hygie other the		12 17. Father's Name ( <i>First, Middle, Last</i> )	ror	est ward	18. Mother's Nam	a (First Midalla		e Govern	iment	
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≥ ′.	and ealth m 27					ch Road,					
0	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of cerneter	t Dispos ry, crem	ition (Name of atory or other plac	ce)	Date	20c. Loca	ition - City or To	wn, State	
Baltimor	t. Pa tmen tant: jury					ark   07/			berland		
g n	permit. Pages Department of Important: If i any Injury or once.		21. Signatury of Furleral Service Licensee			ss of Facility A		-			P.A.
			23a Part 1. Enter the disease, or complications that caused the death. Do n			r Street,			, MD 2	1502 Approximate	9
	Dhuaisian	ev á	23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line. Immediate Cause (Final	4		9,	,			Approximate Interval Bety Onset and D	eath
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of the control of the c	of):	inju	$\sim$				48 110	ury
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ÖĞ,	ificate be executed g physician and as the burial-transit	E E	resulting in death) Last Due to (or as a consequence of):								
09/90	ficate p physics the l	edical	d								
2 2 2 2	certif nding use as	J/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy	I death 3 Ectopic pregnancy				23d. Date of delivery		erv	
Ď	death cer e attendin ed for use	hysician/M	in the past 12 months?  1								fear
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Š,	as tha gned se def	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							tribute to the cause of death?	
law requires that the death certificate seems igned by the attending some sound be detached for use a									No 3 ☐ Prob	3 Probably 4 ☐ Unknown	
		ple	24a. Was an autopsy						24b. Were autopsy findings available prior to completion of cause of		
	The lav	Completed					perf 1□ Yes	ormed? 2 No	death? 1 ☐ Yes	2 No	
N II	<b>ding Physician:</b> Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?  Hospital: 45-4-2-4-2-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4		3CLDOA Oth	26. Place of Dear					
0	his his	<u>۲</u>	The res 2/2010	utpatient Time of	3 L DOA	4 LI Nursing H	ome 5 Res		Other (Specif	y)	
		tion	1 Natural 5 ☐ Pending (Month, Day Year)	Injury	28c. Injur Wor M 1	k? Yes 2 □ No	200. Describe	now injury (	occurred		
VISION	Atten deat sctor	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number,				
5	s after	Certification:	4 ☐ Homicide building, etc. (Specify)  City or Town, State)								
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funera	ledical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the I within 2.		Me	29b. Signature and title of certifier	29c. License number			29d. Date signed (Month, Day, Year)				
			) Jun ( fundel.	D4205Y =				Jul	Tury 6th 2007		
30	101 C. X1		30. Nazze and address of person who completed cause of death (Item 23a) (	(Type, F	Print)		4				
1	1126 25		DR. Grega DONALDSON 912	Se	ton DR	ive, CL	mber	lang	(,MD	2150	ત્રે
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 0 9 2007	L							
DH	IMH 17 Rev 1/2	-04	31. Date filed (Month, Day, Year) 32. Registrar's Signature  JUL 0 9 2007	7.	porte	<del></del>					
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ORIGINAL.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Matthew David Heinz 11:23 A M 2 July 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 263-43-5318 **XX**M 2□ F 51 Director July 2, New Jersey 1956 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at Maryland Anne Arundel Annapolis 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Rosecrest Drive 21403 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 12 h and Mental Hygie 7 Is marked other t Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard P. Heinz Margaret J. Healy 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard A. Heinz/brother 08060 Department of Health a Important: If Item 27 Is any Injury or other trainonce. 42 Spyglass Court Westampton, New Jersey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State Baltimore Crematory 7/5/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each tipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to or as a consequence of): /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate ha Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2200 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending Injury within 24 hours and comments to the Funeral Director: After manufately filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person a

31. Date filed (Month, Day, Year)

JUL 0 5 2007

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Year **Physician** Sandra B. Haverstick 10:32 AM July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 12313 W. Helmsman Way Worcester Berlin If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 📆 F 64 9/19/1942 Director 168-34-9830 PA Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d Inside City Limits show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Columbia Lancaster PA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 555 Mockingbird Drive 17512 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John N. Bair ဥ Margaret Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Haverstick 555 Mockingbird Drive, Columbia, PA 17512 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or otl 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Mem. Gdns. 7/13/07 Columbia, PA 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Immediate Cause ( Physician SCVI EVERAC YRS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 Yes 2 No 9☐Unknown 9 Unknown The law requires that signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examinerr 1**5**21Yes 2∐ No Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: ဂ္ 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

BA 8

State Registrar

DOROTHY 31. Date filed (Month. Dav. Year) 10 2007

29b. Signature and title of certifier

HOLZINORTH

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1 06241

29d. Date signed (Month, Day, Year)

203 SNOW ST. SNUW HILL, MD. 21863

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 23:38 PM <u>Sharon Louise Hartman</u> July 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner E1kton
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Union Hospital of Cecil County Cecil Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1□ M 3\\ T Director 532-42-3969 Nov. 1942 Alaska Usual Residence of Deceden filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-4 show 10c. City, Town or Location 10d. Inside City Limits 10h. County r 28a-f show notified at 10a State 1 ☐ Yes 2 No Maryland Ceci1 North East Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 270 Old Zion Road 21901 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2M No Yes Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rural Mail Carrier U.S. Post Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked oth any Injury or other traumatic event once. Be Unknown ၉ Mary Elizabeth Totemeff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carrie Howell / Daughter P.O. Box 412, 1 Vanessa Avenue, Rising Sun, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 ★Burial 2 Cremation 3 Removal from State Ju1y 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham Cem. 13, 2007 Colora, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility 111 S. Queen St R. T. Foard Funeral Home, P.A. Rising Sun, MD 21911 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line. immediate Cau e (Final disease or condition resulting in peath) Breast **Physician** Cancer unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attence within 24 hours after death To the Funeral Director:

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of cert

30. Name and address of person who com

Martha Hosford, MD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

**ORIGINAL** 

leted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

111 W. High Street, Suite 104, Elkton, MD 21921

D0035653

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend Items 25,27,28a-f per me 1874 09/14/07/dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Randell 29 JUNE 2007 09:14 AM Holt Martin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Marys Hospital Leonardtown St. Marys If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X**M 2□ F Yrs 213-46-7174 61 Director 05/24/1946 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1

Yes 2

No notified Director Maryland St. Marvs Mechanicsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be 29066 Thompson Corner Road USA 14. Race - American Indian, death \ Funeral 20659 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 'natural", or items 1 Never Married 2 Married filed within 72 hours after Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) the Ben Jr. Burroughs Skilled Laborer 12 and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Holt Alice Elizabeth Holley ပ James D 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. 27 Margaret T.Countiss/Sister 37545 Sunrise Ln. Mechanicsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/6/2007 | Helen, Maryland Oueen of Peace 22. Name and Address of Facility Adams Funeral Home PA 21 Signature of aneral Service Vicensee 191 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tron AS Physician pieca /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ON APPROVED BY MEDICAL EXAMINES that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical CERTIFICA IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a o 9∏Unknown 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has t perform 1 Yes 2 this certificate 2 **Z** No HOLT MARTIN 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification; or Attending T⊒Naturat 2 Accident 5 Pending investigation the Funeral Director: A 1 ☐ Yes 2 No Subject choked on food. death. 06/29/2007 9:14 a<sup>M</sup> 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 25500 Point Look-4 ☐ Homicide Hospital out Road, Leonardtown, MD Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the an 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 0 D60888 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKHI KRISHNAN MD LEONARDTOWN MARYLAND 20650 31. Date filed (Month, Day, Year) State 2007 JUL 0 9 Registrar

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>			ealth a D <i>eath</i>	and M		giene Reg. No	. UU	7	237	57	
	Physici	an	Decedent's Name (First, Middle, La	st)							2. Date of De Month	aath Da	у	Year	3. Time of		
	/Medi		Sandra Claudine								June	30		07	7:30	a <sup>M</sup>	
4	Examir	ner	4a. Facility Name (If not institution, giv	e street and nun	nber)		`		Location of	of Death			. County	of Death			
			11140 Boyer Lane 5. Social Security Number 6. S	0.4	7. Age (In yrs.	last histoday)	Wort	On 1 Year	If Under 2	24 Hrs	8. Date of Bir		ent	0 Dieb	olace (State o	r Famina	
	Funeral Director			□M 2፟  IF	7. Age (117 yrs.	Yrs.	Months	Days	Hours	Min.	(Month, Da 4/13/1	ay, Year)		Coul	1and	roreign	
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	다 다 S S S S S S S S S S S S S S S S S S	Olre	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of W	/hat Cou	ntry?		
	ath w	ral	11140 Boyers Lane	1			_	578				USA					
	er de	une	11. Maritat Status	12. Was Dece	ces?	J.S. 13.	Was Dece f Yes, spe	dent of Hi cify Cuba	ispanic Orig n, Mexican,	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	o-		k, White,	can Indian, etc.		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	Θ		1 🗆 Yes	20 No	Specify:				Specify:	Bla	ck		
9	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f show he Medical Exercite roughte notified at	Completed by Funeral Director	15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ation			16b. K	ind of Bu	siness/In	dustry		
215	Media	ple	(Specify only highest gra Elementary/Secondary (0-12)	(1 College (1	-4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired	during most )	t of workir	ng						
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pu	al Hy al Hy al oth	Be	17. Father's Name (First, Middle, Last						18. Mother	r's Name	(First, Middle	, Maider	Sumame	θ)			
yla	Meni Meni arke	10	John Thomas Boyer						Anna								
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other then "neturel; or Iteme 23a or 28a-f show any Injury or other traumatic event, the Medical Exercities must be notified at ance.		19a. Informant's Name/Relationship (Type, Print)  Charles L. Hall / Spouse  11140 Boyer Lane Worton,														
	1 and Heelth I'm 27			Spouse	20h				ane w		111			City or To	own, State		
Baltimore,	or of		20a. Method of Disposition  1												Jwii, State		
Ę	rt. Pa		4 Donation 5 Other (Special 21. Signatury of Funeral Service Lice		of	Love C	emete	ry -	/	7/7/2	2007	Wort	on,	MD			
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	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line.								,		Onset and		
	Physician /Medical		disease or condition resulting in death)	a. Due to (	oras a conse	nuence of):	C	レイリ	7) 17	ver	meta	<u>.543.</u>	372		1 yr		
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0,	e exe	EX	resulting in death) Last	Due to (	or as a consec	quence of):											
8760,	The law requires that the death certificate be executed to be been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	•	d													
9	eath certific ettending p	/Mec	IF FEMALE:	23c. If yes, out	nome of aroun	2504											
Вох	ettend for us	lan	23b. Was decedent pregnant in the past 12 months?	1☐Live b	irth 2 ☐ Feta antattime of	al death 3□	Ectopic p						23d. Date Mon		•	r'ear	
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno		uean s_	1 Other (s)	ecity)									
	res that the de signed by the e be detached t		Part II. Other significant conditions	ontributing to de	ath but not res	sulting in the u	nderlying o	ause give	en in Part I.		23e. Did 1	tobacco	use contr	ibute to t	he cause of c	leath?	
of Vital Records,	puires	d by	Asome								10	Yes 2	□No	3 🗌 Prot	bably 4	Inknown	
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tal	un: T	0	25. Was case referred to medical						26 Place	of Death	1 Yes	2DNo	1	☐ Yes	213 No		
Ξ	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital:	npatient 2	] ER/Outpatien	t 3 D	Othe Othe		rsing Hon	1		6 □Othe	er (Specil	(v)		
0	ng Ph ter th neral	ä	27. Manner of Death	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	1	28c. Injury Work			8d. Describe	how inju	ry occurre	ed			
Division	endir sath. or: Al	Certification:	2 Accident investigatio	ו			М		Yes 2 N	No							
Ξ	r Att	Ę	3 Suicide 6 Could not be determined	280. Place	of Injury - At h	nome, farm, str	eet, factor	y, office		2	28f. Location ( City or To			er or Rura	al Route Num	iber,	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.		00- 0-4/1														
	Hosi 74 ho Fund tely f	Ilca	29a. Certifier   Certifying Pl (Check only 2   Medical Exal	niner: On the ba	sis of examina	owledge, death ation and/or in	n occurred vestigation	at the time, in my or	ne, date and pinion, deat	d place, a th occurre	and due to the ad at the time,	date an	) and mai d place, a	nner as s ind due t	tated. o the cause(s	:)	
	ithin ( o the	Medical	29b. Signature and title of certifier	and mann	o sidied.		29	c. License	number			29d. Da	te signed	(Month.	Day, Year)		
	F ₹ F 8		1		MA		1		173	5		7	101	07			
	12		30. Name and address of person who	completed caus	e of death (Ita	m 23a) (Tune	- 1	0 )	1 ( )			ι	121	0			
	Ms		Frederick Del	boy M.			-	НП	RD	Chr	STCTTO	1110	mn	21	620		
	Sta		31. Date filed (Month, Day, Year)		trar's Sign	ature	A	20		- 1 hr (							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20<u>07</u> 29 6:00AM PATRICK HENSON JUNE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) JOSEPH RICHEY HOSPICE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MARCH 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) Days Months Hours Min. Country) MARYLAND 1 M 2 □ F 1952 577-72-8466 55 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No PRINCE GEORGE'S PALMER PARK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 U.S.A. 7733 OXMAN ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∄No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: BLACK Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER PRIVATE 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RAYMOND LEROY HENSON AGNES L. QUEEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RAYMOND J. HENSON/BROTHER 13916 HEATHERSTONE DRIVE BOWIE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Laurial 2 ☐ Cremation 3 ☐ Removal from State LANDOVER, MARYLAND HARMONY CEMETERY :7/9/2007 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final unknown disease or condition resulting in death) Due to (or as a consequence Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Year 5 Other (specify) 9 Unknown

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

Director

Funeral

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**Funeral** 

Director

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death with the Maryland

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Baltimore, Maryland 21215-0036

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or Vital Records,

The law requires that the death certificate be executed

To the Hospital or Attending

Examine physician and is the burial-trans resulting in death) Last

Physician/Medical

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Completed

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Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

25. Was case referred to medical examiner?

Hospital:

2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence

2 -No 1 TYes 6 Other (Specify) HOSDICE

28c. Injury at Work? 28d. Describe how injury occurred 1 □ Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Baltimore MD 21201

24a. Was an autopsy performed

2

1∐ Yes

29b. Signature and tile of certifier

5 ☐ Pending investigation

6 ☐ Could not be

29c. License number 1)24170 29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Entaw St

Kichey 31. Date filed (Month, Day, 0 9 2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

			1- For State of Maryland / Dep	partment of Health and ertificate of Death		giene Reg. No.	) 7 -, 4
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of De Month	2.40	3. Time of Death 3:37 A M
	/Medio		WILLIE L. HINES  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Death	J.37 A
	Exami	ier	SOUTHERN MARYLAND HOSPITAL	CLINTON		PRINCE GE	EORGE'S
	Funeral Director		5. Social Security Number 578-62-1131 6. Sex 1 7. Age (In yrs. last birthday 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Hrs. 8. Date of Birt (Month, Da AUG 28	y, Year) 1943 9. Birth Cou	place (State or Foreign ntry) BAMA
	pu "		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	ocation		1,	10d. Inside City Limits
	faryla shoved at	ō	MD PRINCE GEORGE'S CLINTO				1 Yes 2 No
	the N 28a- notifi	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	ntry?
	h with	al Di	5901 BEDFORD LANE	20735		U.S.A.	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi 1 ☐ Yes 2 ▼ No Specify:	P (Specify Yes or No- uerto Rican, etc.)	Black, White,	etc. LACK
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and	ould be fill I Mental H narked oth	Be	17. Father's Name (First, Middle, Last)  EULISH HINES		Name (First, Middle, SHEP	· '	
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	s 1 and 2 of Health a ltem 27 Is other trai		IMMID MINDO/ WILL	1 BEDFORD LANE C			
Baltimore,			20a. Method of Disposition  1  ☐ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		72/2007	20c. Location - City or To	
Balti	permit. Page Department of Important: If any injury or once.			22. Name and Address of Facility  474 LANDOVER ROA		KINS FUNERAL	L HOME 20785
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ether of nearly in Cause (Disease or injury that initiated events				
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<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute to t Yes 2□No 3□Pro	
Ö	law rec as beer 2 shou	Completed	Nicheter Mellitus		24a. Was		opsy findings available
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ita	yslcian: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of	Death (Check only o		
<u> </u>	ys dir	일	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			dence 6 □Other (Speci	ify)
on C		jon:	27. Manner of Death 28a. Date of Injury 28b. Time 1 2 Natural 5 □ Pending (Month, Day Year) Injury		28d. Describe I	how injury occurred	
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	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To the within 2 To the complex	Me	29b. Signature and title of certifier	29c. License number	0 0	29d. Date signed (Month,	, Day, Year)
			167.11.	D198	89	06-26-	07
A	(6)		30. Name and address of person who completed cause of death (Item 23a) (Type				2 6 6
-	- 6		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Southern 1	tuc SE -	DC 2	0037
	Sta Regist		1111 0 9 2007 Fee 1. Soul				

/Media	an	1. Decedent's Name (First, Middle, Las Hattie V. Hallman	,							2. Date of D Month une 1	Da	007 Ye	ar .	Time of Death : 43 PM
Examir		4a. Facility Name (If not institution, give 203 Che11 Road		er)		4b. City, To Jappat					40	c. County of C arford		
uneral irector		577-24-5562		Age (In yrs. last i	birthday)_ Yrs.	If Under 1 N	Year Days	If Under 2 Hours	Min.	8. Date of E (Month, 1 Lug. 1	Day Year	) .	Country)	State or Forei ham, V
8a-f show	ector	Usual Residence of Decedent  10a. State  10b. County  NON	e	10c. City, To Washir		, D. (							1]	side City Lim
3a or 2 st be n	al Dir	10e. Street and Number 14 Crittenden Stre	et, N.E.			10f. Zip Co 2001		720				itizen of Wha U.S.		
ral', or Items 23a or 28a-f show Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Tes 2 [ If Yes, Give Year or Dates	s? XNo	1	/as Deceden Yes, specify		panic Orig , Mexican Specify:	jin? (Spec , Puerto P	cify Yes or Nican, etc.)	10-	14. Race - A Black, V Specify: B	Vhite, etc.	dian,
od other than "natural", event, I're Medical Ex	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	Sa. Decede (Give k life. Do	ent's Usual C and of work of ONOT use i	Occupat done du retired)	ion Iring most	of workin	g		Vate	ess/Industry	
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ant: If item 27 is marked o jury or other traumatic eve		19a. Informant's Name/Relationship (7) Doris G. Carey/Gre										or Town, Star and 21		)
t: If item?		20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗆	Removal from Stat	20b. Place ceme	of Disposi etery, crema	ition (Name atory or othe	of or place,	,	Da	ite	20c. L	ocation - City	or Town, S	tate
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Registrar

State

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NORMA HONICK

20850

ATUL ROHATGI, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division or Vital Records. filled in by the f within 24 hours a

To the Funeral I

completely filled

Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RSM, MD. 1500 Forest Glen Rd. Silver Spring, Barbara Supanich, 32. Registrar's Signature 31. Date filed (Month, Day, Year, JUL 1 1 2007

Suparich, PSM MD

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0065485

29d. Date signed (Month, Day, Year)

MD

Amended #16b, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07/12/07, Allegany Co. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician 12:45 2007 JULY 6TH, RICHARD CASPER HADLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **X**M 2□ F Director 213-24-5426 78 MARYLAND SEPT. 29,1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 TXNo Director KEYSER MINERAL WV 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with ROUTE 1, BOX 259 26726 U.S.A. Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: ģ 3 Widowed 4 Divorced WHITE "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical KELLY-SPRINGFIELD e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) -TIE-COMPANY Tire Co. MACHINE OPERATOR 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental be and Menta HELEN PHILADELPHIA MILLER CASPER HADLEY ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important; If item 27 Is any injury or other tran ROUTE 1, BOX 259, KEYSER, WV DORIS G. HADLEY / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MINERAL BAPT. CH.CEM. 07/10/2007 4 Donation 5 Other (Specify) FORT ASHBY, WV 21. Signature of Funeral Service License 22. Name and Address of Facility UPCHURCH FUNERAL HOME, INC. THACKURO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATHY JAKNOSO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cristanio-3 CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, ding physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year þ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ END STAGE RENAL DISEASE, HYPERTENSION, DIABETES 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an **MELLITUS** has autopsy performed death? 1 ☐ Yes 2 □ No 1∐ Yes 2√ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F s after death. Il Director: After d in by the funera After 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by determined 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

To the I within 2

5 nds

State Registrar 31. Date filed (Manth, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D31875

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #29d, nls, 06/19/07, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Amend Item 23b per dr., 6869, 07/30/97dbb 1 - State Registra 1. Decedent's Name (First, Middle, Last) Month 06 **Physician** HOUDERSHELDT TAMMY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2**X**F Months Days Hours 08/06/1963 218-76-3402 43 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified Directo MD **Allegany** Cumberland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21502 USA 11505 Sycamore Street Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Domestic Homemaker other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental H 27 Is marked of traumatic ever Danforth Buchanan Linaburg, Jr. Joan Irene (Chenowith) Valentine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau 11505 Sycamore Street, Cumberland, MD 21502 Danforth B. Linaburg / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 06/20/2007 Cumberland, MD 4 □Donation Cumberland Crematory 5 Other (Specify) 21. Signatury of Fu eral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, PA 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical **Examiner** Examiner Division or Vital Records, P.O. Box 68760,

3. Time of Death

1X Yes 2 □ No

Approximate Interval Between Onset and Death

3 ☐ Probably 4 ☐ Unknown

Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

0315

Completed by Physician/Medical Be ပ္ Certification:

1 ☐ Yes 2 Z No

27. Manner of Death

1 Natural

Immediate Cau disease or cond resulting in dea	dition	a. METASTATIC SMALL CELL Due to (or as a consequence of):	L CARCIN LU	NG March
Sequentially list if any, leading a cause. Enter U Cause (Disease that initiated ev- resulting in dear	o immediate Inderlying e or injury ents	b. Due to (or as a consequence of).  c		
IF FEMALE: 23b. Was decer in the past 1 □ Yes 9 □ Unkno	t 12 months? 2 No	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other si	gnificant conditions	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
			24a. Was an autopsy performed? 1  Yes 2  No	24b. Were autopsy findings availa prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case re examiner?	eferred to medical	26. Place of Death	(Check only one)	

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buri 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds 625 querue LAMAN m.D.DAMPI . Date filed (Month, Day, 32. Registrar's Signature State JUN 1 9 2007 Registrar **ORIGINAL** 

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of

1 Inpatient 28a Date of Injury

(Month, Day

			For	Pleas	se Type or State						Ensure A			_	e.		
			1 - State Registrar					Cer	tifica	te of L	Death		Reg. No.	.200	17	237	65
	Physicia	an	1. Decedent's Nam-									2. Date of D Month	eath 1 <sup>Day</sup>	200	ear,	3. Time of Dea	
	/Medic		Yolanda						41- 01-	T	Location of Doct					9:10 a	M .
	Examin	er	4a. Facility Name (I Western M Frostburg	lary land Nursin	give street and no Health g & Reha	Syste b Ce	em's nter	A &			tburg			Alleg	any	ace (State or Fo	roiss
L	Funeral Director		5. Social Security N 214-07-3	537	6. Sex 1 ☐ M 2 🕱 F	/. Age (	In yrs. las	Yrs.	Months		Hours Min.	(Month, E	ay, Year) 1 <b>st 15, 1</b>		Count	yland	oreign
	land ow ut		Usual Residence of 10a. State	10b. County		1	0c. City, 7	Town or Loc	cation						10	d. Inside City L	imits.
	Mary L-f sh fled a	tor	Maryland	Alle	egany		Mot	unt Sava	age							1 X Yes 2[	] No
	th the or 28% e not	Director	10e. Street and Nu	mber 1171	7 Bishields	Lane			10f. Z	p Code			10g. Cit	izen of Wha	at Count	ry?	
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	items ner m	Funeral	11. Marital Status	ried 2∐ Marrie	12. Was De Armed F		er in U.S.	13. V	vas Dece f Yes, sp	ecify Cuba	spanic Origin? (S n, Mexican, Puer	to Rican, etc.)	10-		White, e		
2	urs aff	by	3 ☐ Widowed		If Yes, O	Give/		1	☐Yes	2 <b>X</b> No	Specify:			Specify:	Whit	e	
5	72 hor	eted	(Spe	15. Decedent's	s Education grade completed	d)		16a. Deced	kind of w	ork done d	turing most of wo	rking	16b. K	ind of Busir			
717	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healih and Mental Hygiene. It of Healih and Mental Hygiene. Or item 27 is marked other than "natural", or item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Seco		T	(1-4or 5+)		clerk	DO NOT	use retired			po	st office			
2	be file tal Hy d oth	Be	17. Father's Name		ast)						18. Mother's Na		e, Maiden	Surname)			
2	hould d Men narke natic	은	MICNAEI  19a. Informant's N	Bishields	in (Time Print)			19h Mailin	a Addres	s (Stroot :	Congetta and Number or R	a Principe	her City o	or Town St	ate Zin i	Code)	
_	and 2 sl ealth an n 27 is r ier traur					ephew						Potom		Maryla		20854-	
ນົ	s 1 and 2 if Health item 27 l		20a. Method of Disposition 20b. Place of Disposition (Name of Date											ocation - Ci			
2	Pages nent of ant: If its ary or o		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Saint Patrick's Cemetery  July 18, 200'											Savage	Ma	ryland	
Dallillo	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility														
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Į,			mock, or hea	art failure. List o	only one cause or	each line.	-		l 1	105	y, such as caldia	O C	arrest,			Interval Betwee Onset and Dea	
	Physician /Medical		disease or condition resulting in death)	on		o (or as a			1/12	174	MILU	14-			250	my it	en
	Examiner				h (	COR			RI	ERY	DUSEAST	· ?			451	W 54	eur:
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	e executed an and irial-transit	Examiner	that initiated event resulting in death)	S	c	o (or as a	consequé	nce of):								_	
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X O O	requires that the death certificate be een signed by the attending physicis rould be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12			e birth 2	Fetal d	leath 3	Ectopic Other (	pregnancy	,			23d. Date of		ry Day Yea	ar
	the de	ysic	1 ☐ Yes 2' 9 ☐ Unknowi		9□Unl	egnant at ti known	me or dea	(III) 5L	Joulei (	specify) <u> </u>							
Ţ.	s that ned by	by Ph	Part II. Other sign	ificant conditio	<b>ns</b> contributing to	death but	not resulti	ing in the ur	nderlying	cause give	en in Part I.	23e. Dio	tobacco	use contrib	ute to the	e cause of deat	th?
cords	equire en sig ould bo	ed b										1	]Yes 2	No 3	☐ Proba	ably 4 ∐Unk	nown
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<u> </u>	The cate h	Con										pe: 1∐ Yes	formed? 2 X No		ath? ]Yes	2□ No	
VITAI	Physiclan: r this certific ral director,	Be	25. Was case refe examiner?		Hospital:					Oth	26. Place of De						
5	Phys r this ral dir	٠ <u>.</u>	1 ☐ Yes 2 ☐		28a. Da	Inpatient te of Injury	2	R/Outpatien 28b. Time of		28c. Injur	v at	Home 5 ☐ Re				')	
O	Attending r death. ector: After by the fune	ation	1 Natural 2 ☐ Accident	5 ☐ Pending investig		onth, Day	Year)	Injury	M	Wor 1 □	k? Yes 2 □ No						
JIVISION OF	al or Attendii after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ned   Zoe. Fla	ce of injury		ne, farm, str	eet, facto	ory, office			(Street a. own, Stat		or Rurai	Route Numbe	r,
	Hospita 4 hours Funera tely fille	edical C	29a. Certifier (Check only one)		g Physician: To t Examiner: On the		examination										
	To the within 2 To the complet	Med	29b. Signature and	d title of certifier	and m	umer sidle			2	9c. Licens	e number		29d. Da	ate signed (	Month, l	Day, Year)	
	4		•		9tholm					026	907		JU	Ly 1	7 2	2007	
7	٢		30. Name and add	dress of person	who completed ca	ause of dea	ath (Item 2	23a) (Type,		,	/ / _		_	-('	7		
	nds			dhu 92	5 B.Sho	P CU	alsh 1	Kol	Lu	mber	Caps.	M.D	21	503	_		
	Sta Regist		31. Date filed (Mo	JUL 1	<b>7</b> 2007 32	neyenar	Signatu	K.	s pa	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10.40 AM 200 Andres Ostapczuk Ilasevich /Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner 5+ Agnes timore, r 1 Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, May 17, 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1952 **Funeral** Months 1⊠M 2□F 223-79-0126 Paraguay 55 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 TXNo Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 3673 Hineline Road Argentina Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Foreman Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd Mental I Roman Ostapczuk Melania Ilasevich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any injury or other trau 20406 Sawgrass Drive, Montgomery Village, MD 20886 Nuno M. Passarinho/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State July Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. KenSkile 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mesothelioma Immediate Cause (Final Metastatic Pleural **Physician** o months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. To Be Completed by 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page perform 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury s after deameral Director; After 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

Completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16354 200

15

State

Registrar

31. Date filed (Month, Day, Year)

E.W.COLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. ASNES GOO CATON AVE, BALT, MORE,

10 2007 Segistrar's Signature

10 2007 Segistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Jesse W. Johnson June 30 2007 2017 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center <u>Annapolis</u> Anne Arundel 8. Date of Birth (Month, Day, Feb 6 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1<del>√</del> M 2□ F Months Min. 78 Yrs. 218-28-1579 Mary land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Inmortant: If Item 27 is marked of other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Yes 2□No Maryland Anne Arundel Director Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 A Bloomsbury Square 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Date ∰: 951 - 53 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 9th 0 Mail Handler Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles M. Johnson Mary Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 4 0 1 19a. Informant's Name/Relationship (Type. Print) William Collins(Step Son) 1904 E Copeland St. Apt E Annapolis, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 7-6-07 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. 21. Signature of Funeral Service Licenses Windlame Reddees of Eacil Sons Mortuary, 821 West St. Annapolis, Md. MO048 , seese 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LUNOVY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any localing is in indicate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2☑No 3☐ Probably 4☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) J. 1 ☐ Yes 2 ☐ No Minpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Year) (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death I Director: d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and dress of person who co npleted cause of death (Item 23a) (Type, Print) Eileen Maci medical 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

	1 - State Registrar  1. Decedent's Name (First, M	liddle Last		Certifica	ate of D	Peath	2. Date of De	Reg. No.	2001	(10/0)
cian							Month	Day 7	Year	3. Time of Death
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al	5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday) If Und	ter 1 Year	If Under 24 H	s. B. Date of Bi	rth		olace (State or Foreign
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Funeral Director	Maryland Tal	bot	East					0		
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era	234 Brookwoo		dent Ever in U.S.		21601	nanic Origin?	Specify Ves or N	US 1	SA 4. Race - Americ	can Indian
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þ	3 X Widowed 4 ☐ Divo	ced If Yes, Giv Year or Da	e ites:	1 ☐ Yes	2 <b>X</b> No	Specify:			Specify: Whi	te
Completed by		dent's Education ghest grade completed)	16a	. Decedent's Us	sual Occupat	ion	orkina	16b. Kin	d of Business/Inc	dustry
ğ	Elementary/Secondary (0-1		-4or 5+)			iring most of w	og			
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Be	17. Father's Name (First, Mid	•					ame (First, Middle			
2	Stanley Josep		101		- 1		ca Andrz			
	Jill Andrew/D	7 7 7 7					Rural Route Numb			Code)
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	1100000 1 1315	801- Dun	W 1 1001	MidS	hore (	Cremati	on Cente Cambridg	r, P.	O. Box :	1464,
	23d. Part1. Enter the displace	e, or complications but ca	used the death. Do	not enter the m	ode of dvina.	such as cardi	ac or respiratory a	rrest	21013	Approximate
	shock, or heart failure. Immediate Cause (Final	List only one cause on ea	ich line.	4.4	, 3.		,			Interval Between Onset and Death
	disease or condition resulting in death)	d	or as a consequence	3 / 1					- 4	years
					Keen					Hood
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	or as a consequence	stery d						years
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Physician/Med	IF FEMALE:									
lan/	23b. Was decedent pregnant in the past 12 months?	1□Live bi	ome of pregnancy th 2 Fetal death					23	3d. Date of delive Month	ory Day Year
sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□ Unkno	ant at time of death wn	5 Other (	specify)				WORLD	ouy rour
	Part II. Other significant con	ditions contributing to de	ath but not resulting is	n the underlying	Callee diver	in Part I	23e Did 1	obacco us	e contribute to th	ne cause of death?
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	05.10						1 Tes	2.2No		212 No
Be.	25. Was case referred to med examiner?	Hospital:			Other		eath (Check only	-7		
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tlor	1 Natural 5 ☐ Pe 2 ☐ Accident inv			njury M	Work?	es 2 □ No	Edd. Bosonibo	now injury	00001100	
Ifica	3 ☐ Suicide 6 ☐ Co	uld not be 28e. Place	of Injury - At home, fa	ırm, street, facto			28f. Location (	Street and	Number or Rura	I Route Number,
Certification:	4  Homicide del	buildin	g, etc. (Specify)				City or To			
	29a. Certifier Certi	fying Physician: To the	pest of my knowledge	e, death occurre	d at the time	, date and plac	e, and due to the	cause(s) a	and manner as st	ated.
edicai	(Check only 2 Medi	cal Examiner: On the ba and mann	sis of examination an	d/or investigation	on, in my opir	nion, death occ	curred at the time,	date and p	place, and due to	the cause(s)
Ž	29b. Signature and title of cer	tifier 3/1	1.	2	9c. License	number		29d. Date	signed (Month, I	* * * * * * * * * * * * * * * * * * * *
	•	MILLON	117		DE	5933			7.9.07	
	30. Name and address of per	son who completed cause	of death (Item 23a)		ſ	1	, ,	_		•
1	MICHAEL (R)	JULEY MD	610 D	UTCHM	ANS	LANG	EAS	STON	1,117	21601
	31. Date filed (Month, Day, Ye		strar's Signature							

DHMH 17 Rev 1/2001

Stanley Jastrzab Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician JETT** GWENDOLYN 200% /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S LANHAM DOCTORS HOSPITAL 8. Date of Birth Month, Day, JAN 18 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year 948 Hours 1 □ M 2 □ F Months 59 578-64-0685 Director WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov NEW CARROLLTON PRINCE GEORGE'S MD 1 X Yes 2 □ No Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7604 FONTAINEBLEAU DRIVE # 230 Items 23a 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify BLACK ò Specify. 3 ☑ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-00 Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th HOUSE WIFE PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GREEN O'NEAL MAE CUMMINGS 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE R. GOODWIN/DAUGHTER 7604 FONTAINEBLEAU DR. #230 NEW CARROLLTON, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 7/7/2007 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner lor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No autopsy performed 2**X**No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 3□ DOA ပ 2 ER/Outpatient 28a Date of Injury 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who of impleted cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JUL 0 9 2007

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1500

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUL 9 2007 2:30 A M WOODROW WALTON JENKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY It Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 X M 2 □ F Yrs. Director 87 MAY 26, 1920 VIRGINIA 577-18-1318 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County 27 is marked other than "naturel", or items 23e or 28e-f show traumstic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Directo MARYLAND MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11616 SEVEN LOCKS ROAD 20854 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. I other than "naturel", or ite Amed Follows:

1 X Yes 2 No
If Yes, Give
Year or Dates: 1943-1970 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) 5+ CERTIFIED PUBLIC ACCOUNTANT & PRIVATE PRACTICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fit Health and Mental Hitem 27 is marked oth Be HENRY P. JENKINS ADA BLANCHE COATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 26481 VIA MARINA, MISSION VIEJO, CALIFORNIA 92691 STEPHEN W. JENKINS/ SON other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itsi
any injury or ott 1 🔀 Burial 2 □ Cremation 3 □ Removal from State OCTOBER 26, 2007 ARLINGTON NATIONAL CEMETERY 4 □ Donation 5 □ Other (Specify) ARLINGTON, VIRGINIA
PUMPHREY FUNERAL HOME/
7557 WISCONSIN AVENUE 22. Name and Address of Facility ROBERT A. PUM BETHESDA-CHEVY CHASE, INC. 75 MOO335 BETHESDA, MARYLAND 20814-3501 21. Signature of Funerat Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Lary Lating 15 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine attending physicien and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy tindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s 1 Yes 2 X No Hospital or Attending Physician: Be 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: tnjury at Work? 1 XNatural 2 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) Medi 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 07-10-2007 0101240449 (VA) 70+1 NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 USN MC JAMES R. HOLLIS LT 31. Date filed (Month, Day, Year) State 10 Registrar JUL

07-05198	
Raymond	W.

Raymond W. Ja		on, Jr Sta 1- For State Registrar	ate of Maryla		artment of rtificate of			Menta	al Hyg		Reg. No.	200	7 2377
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Medical Exami	ner	Raymond W11 4a. Facility Name (if not institutio				p. City, To	wn orlo	ocation of		July 6, 20	007 4c. County	of Deatl	2300 hrs
		Prince Georges Hospi		inber)	]"	Chever		ocation of	Death		Prince		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under		If Under		8. Date of B	irth(MM/DD/YYY		rthplace (State or
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x 68760 th certificate b ttending physi	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of preg irth	remark.	al death	3	Ectopic	pregnan	су	23d. Date Month		Day Year
Box 6 death cer the attendi	sicia	1 Yes 2 No 9 Uni		ant at time of de	eath 5 Oth	er (Specif	fy)						
	Phy	Part II. Other significant condit	9 Oliking		esulting in the ur	nderlying o	ause giv	en in Par	t I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
, PO.	b		·							1 Y	es 2 🗸 No	3 Pro	obably 4 Unknown
of Vital Records,  ng Physician: The law require  nfer this certificate has been si  meral director, page 2 should t	Completed									24a. Wa	s an 24b		utopsy findings available completion of cause of
eco ne law te has ige 2 sl	duc			<u>, , ,</u>						per	formed?	death?	
Vital Rec ysician: The I his certificate	Be	25. Was case referred to medica			-	- 26	3.Ptace c	of Death (	Check or				
Vita hysici this o	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2 🗸	ER/Outpatient		··			Home 5	Residence 6		er.
n of Jing Ph		27. Manner of Death  1 Natural 5 Pend	28a, Date Jul 6, 20	of Injury Day,Year) 007	28b. Time of In 2224 hrs	ijury 28		at Work?	P		e how injury occu n struck by a		
Division ra for Attendir ra after death.	cati	Pend	stigation		ome, farm, stree	t factory				28f Location	(Street and Num	nher or R	tural Route Number, City
Division  To the Hospital or Attendif within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:		d not be	Interstate/		t, lactory,	Jilico Du	iiding, etc			State) 450/ BW Parkv		
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Pi	hysician: To the bes	t of my knowled	lge, death occurr	ed at the t	ime, date	e and plac	ce, and c	lue to the ca	use(s) and mann	ner as sta	ited.
To the vithin of the comple	Medical	one) 2 Medical Exa	miner:On the basis and manner s	of examination a tated.	and/or investigati	on, in my o	pinion,	death occ	urred at	the time, dat			
	ž	29b. Signature and title of certifie	~				License						onth, Day, Year)
		ng m	, mos				O.C.M	I.E.			July 7, 20	<i>1</i>	
1 (3)		30. Name and addess of person Ling Li, MD Assista	nt Medical Exar	miner 111	Penn Stree	t, Baltim	ore, N	1D 2120	01				
s	tate	31. Date filed (Month, Day Year)	32. Re	egistrar's Signar	W								
Regis		JUL 1 1 2007	Barre	D. An	wa								

			1 - For State Registrar	State of Mary			of Health and of Death		ene 007	23773
	Physici	့ ၁၈	Decedent's Name (First, Middle, Last,	)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Inez	Yvonne Jo	ones			July 1	2007	12:45pM
	Examin	er	4a. Facility Name (If not institution, give	street and number)			wn, or Location of De		4c. County of Dea	
			533 Rosie				Washing		Prince	
	Funeral		5. Social Security Number 6. Sec	IM 2FTE	yrs. last birthday)	If Under 1 Months E	Year If Under 24 H Days Hours Mi	n. (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		112 20 1270	X 85	Yrs.			July 29	9,1921 A	rkansas
	and w		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryi t aho	5								1 XYes 2 □ No
	18 A	ect	Md Prince (	Georges	Fort V	10f. Zip Co		10	g. Citizen of What Co	ounter?
	with a or	<u>=</u>		Road		207		10	USA	ountry:
	72 hours after death with the Maryland natural', or items 23a or 28a-t ahow dical Examirat must be rediffed at	Funeral Director	<del></del>	12. Was Decedent Ever	in 11 S 13			(Specify Ves or No-	14. Race - Ame	erican Indian
	ter d	ä	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0.0.	If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu	erto Rican, etc.)	Black, Whi	
336	al', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 2	₩o Specity:		Specify: B	lack
ŏ	2 hor		15. Decedent's Edu	cation	16a. Dece	dent's Usual C	Occupation	1	6b. Kind of Business	
215	within 7. ene. than "n	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work of DO NOT use i	done during most of w retired)	vorking		
21215-0036	d wit	Completed	12	00110g0 (1 401 04)		Sal	es Cler	k	Private	Industry
Þ	e filed within al Hygiene. I other than '	Bec	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, M	aiden Sumame)	
<u>a</u>	ould be Mental arked o	ToE	Dennis P	arker			Roxa	anne Mo	Farland	
altimore, Maryland	S D E E		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (S	treet and Number or	Rural Route Number,	City or Town, State,	Zip Code)
Σ	is 1 and 2 of Health a item 27 le other train		Karen Miller/	Daughter	201	Blackl	perry Dr.	.,Fort Wa	shington	n, Md 20744
ore	of He item		20a. Method of Disposition	20	b. Place of Dispo cemetery, crei	osition (Name	of or place)	Date 2	0c. Location - City or	Town, State
Ĕ	permit. Pages 1 an Department of Heal Important: It item 2 any injury or other once.		1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emovat nom State				5/2007	Clinton	, Md
aĦ	permit. Departn Imports eny inju	-	21. Signature of Funeral Service Licens					Bluford F		
œ	80 5 8		Churlle 1	2.13 mg	ord	3605 1	4Th St.,	NW, Wash	ington, I	DC 20010
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the c						Approximate Interval Between
1	Physician		Immediate Cause (Final	-	MANIAN	· cs	JC 612			Onset and Death
, i	/Medical		disease or condition resulting in death)	Due to (or as a con	MONAR	7 070	-00-			G MONTHS
	Examiner			ATI	ZIAL F	BRIL	LATION			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con						
	cuteo nd ransi	ami	triat initiated events	HY	PERTUN	roisi	i			
oʻ	exe en ar	EX	resulting in death) Last	Due to (or as a con	sequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner		1						
9	ng ph	Med	IF FEMALE:							
Вох	th ce rendi	an/	23b. Was decedent pregnant 2	3c. If yes, outcome of pre 1□Live birth 2□1		∃Ectopic pregr	nancy		23d. Date of de	•
Э. Ш	that the death certific ed by the attending p detached for use as	SC	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time 9☐ Unknown		Other (speci			Month	Day Year
P.O.	at the I by the	Phy	9 Unknown							
	w requires that been signed to should be det	þ	Part II. Other significant conditions cor	tributing to death but not	resulting in the u	nderlying caus	se given in Part I.	23e. Did toba	<b>&gt;_</b>	the cause of death?
מ	equir sen s ould	ted						1 ☐ Yes	2 No 3 □ Pi	robably 4 Unknown
ö	e law r has be ye 2 sh	Completed						24a. Was an autopsy		utopsy findings available completion of cause of
<u> </u>	The ate h page	Ö						perform	ed? death? XNo 1 ☐ Yes	
ita	Physician: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of D	eath  Check only one	Scotter Town	
Ž	Physic this car	P	1 ☐ Yes 2 No	lospital: 1 🔲 Inpatient	2 ER/Outpatier	nt 3 DOA	Other: 4 🗆 Nursing	Home 5 Residen	ce 6 Other (Spe	cify)
ם	ding P n. After t funera	ë	27. Manner of Death  1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	f 28c.	Injury at Work?	28d. Describe how	injury occurred	
sio	Attending ir death. ector: After by the fune	cati	2 ☐ Accident investigation			М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Attendation of the or after deation of the or or or or or or or or or or or or or	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, str ecify)	eet, factory, of	ffice	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	ital c rs af ral D									
	e Hospital 24 hours a Eunaral I letely filled	edical	(Check only 2 Medical Examil	sician: To the best of my ner: On the basis of exam	knowledge, death	h occurred at t	he time, date and pla- my opinion, death oc	ce, and due to the cau	ise(s) and manner as	s stated.
	분들류 후	Medi	Uney .	and manner stated.					1000	2007
<b>.</b>	To To Com	<	29b. Signature and title of certifier				icense number		d. Date signed (Mont	n, Day, Year)
	2			0		D	203 4 447	)	7/3/0	/
11	$\langle S \rangle = 1$		30. No. 44 and address of person who co							
일			Francis C. King	,MD 12158	Center	al Av	e., Mitc	hellvill	e,Md 207	21
	Sta Registra		31. Date filed (Month, Day, Year)  JUL 1 8 2007	32. Registrar's S	gnature					
1 30	negisti	-11	JOE TO ZOOL	Terrent D.	uparte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Claire Bette Ketcham 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 XF Months Days Hours Min Director 73 577-48-4108 Nov. 4, 1933 Worchester, Mass Usual Residence of Deceden 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 Trinity Drive 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Peter V. Kolonia ၉ Clara Andersen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer L. Ketcham /Daughter 3000 Trinity Drive, Bowie Md. 20715 Saltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 14,2007 ADELPHI, Maryland George Washington Cemetery 21. Signature Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and peath Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-tran and Due to (or as a consequence of): Box 68760 the attending physiciar pe Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.0. detached 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u></u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performe certificate 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) Injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Conter

Mn

		•	For State Registrar		State o	of Marylan	id / Depa	rtmer tifica	e of L	eaith and Death	I Mental I	Reg. No.		7 2377
Phys		n	1. Decedent's Name	, , , , , , , , , , , , , , , , , , , ,	<sub>Last)</sub> 1en Keto	)					2. Date of Month	Death Ly 17,	2007 Year	3. Time of Death 8:30 P M
/Me Exai	dica nine	r	4a. Facility Name (If I						Town, or	Location of De		4c.	County of Deat	
Funei Direct			5. Social Security Nu 056-16-118	ımber 6	Sex Y	7. Age (In yrs.	last birthday) 6 Yrs.		r 1 Year_	If Under 24 H Hours Mi	n. 8. Date of Month	Birth Day, Year) 71920	-	hplace (State or Foreign ountry) Jersey
land Jw			Usual Residence of D 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
e Mary a-f sho		cţo	PA	Frank	lin	G	reenca	stle						1 □Yes 2≹ No
h with th		al Dire	10e. Street and Number 15021		d Line R	Road		10f. Zi	Code 172	25		_	izen of What Co USA	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at		by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Dec Armed F d 1 ☐ Yes If Yes, G Year or I	cedent Ever in U orces? 2 <sup>1</sup> No ive Dates:	.S. 13. V	Vas Dece f Yes, spe		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes of erto Rican, etc.	No-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
72 hou "natura dical E			(Specif	15. Decedent's fy only highest			16a. Deced	lent's Usu	al Occupa ork done d	ition uring most of w	vorking	16b. Ki	ind of Business/	
d within giene. er than the Me		Completed	Elementary/Second	dary (0-12)	College	(1-4or 5+)	lite. L		emake				Home	
d be file ental Hy ced othe		To Be	17. Father's Name (F	<sup>First, Middle, Li</sup> inar Wi							ame <i>(First, Mic</i> alkoner		Surname)	
2 should be and Mental is marked or aumatic ever			19a. Informant's Nam					_				-	or Town, State, 2	,
tem 27			Jorma Ke		band	20b. F	1502 Place of Dispo cemetery, cren				Rd. Gre		tle, PA	
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permit. Departr Importa	ouce.		21. Signature of Eur	peral Service Li	censee	ver In	22						on Fune: e, PA 1	ral Home 7225
				t failure. List o	omplications that nly one cause on	caused the deat each line.	1	er the mo	de of dying	g, such as card	iac or respirato	ry arrest,		Approximate Interval Between Onset and Death
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ate be e		edical E			d									
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		sician/M	IF FEMALE: 23b. Was decedent   in the past 12 n 1 □ Yes 2 ☑ 9 □ Unknown	nonths?	1□Live	utcome pf pregnation 2 Teta birth 2 Teta gnant at time of conown	al death 3	]Ectopic p	regnancy pecify)				23d. Date of de Month	livery Day Year
that the led by the detach	i	/ Phy	Part II. Other signific	cant condition	s contributing to	death but not res	ulting in the ur	nderlying	cause give	n in Part I.	23e. [	Did tobacco u	use contribute to	the cause of death?
equires equires en sign		ted by									_ 1	☐ Yes 2	□ No 3□ Pi	robably 4 Miknown
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To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Hornicide	investiga 6  Could no determin	t be 28e. Plac	e of injury - At h	ome, farm, str	eet, facto		′es 2 No		on (Street an Town, State		ural Route Number,
e Hospita 24 hours e Funeral etely filled	.	edical C	29a. Certifier (Check only one)	1 <b>Certifying</b> 2  Medical E	Physician: To the kaminer: On the land man	e best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurre vestigatio	at the tim	ne, date and pla pinion, death o	ince, and due to courred at the ti	the cause(s me, date and	) and manner as d place, and due	s stated. e to the cause(s)
To the within To the		Me	29b. Signature and to	title of certifier	nuh	W		29	c. License	number 3	96	29d. Da	te signed (Mont	th, Day, Year)
١	8	-	30. Name and addre			ise of death (Iter		Print)	11	26	ala	٨,	e }	110/11
The growth of	્ય Stat	е	31. Date filed (Month	h, Day, Year)		Registrar's Signa		e 9		18	ages.	c fo w	in' Wi	17176

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 7, 3:35A July Betty J. Keplinger /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil 37 Pine Bluff Lane E1kton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 5, 1 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months 1 ☐ M 2 🔀 F 1932 Yrs. PA 208-24-1035 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Ceci1 E1kton MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. 21921 U.S.A. 37 Pine Bluff Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ★ o If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3altimore, Maryland 21215-0036 Completed by White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f rand Mer. permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. P Elizabeth Glazer Oliver McClintock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeffrey Drive, Middletown, Patricia Chambers/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 11,2007 Upper Track, WV Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Kline 22. Name and Address of Facility 21. Innature of Juny 1,6 rvice Licensee Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) etastah'c **Physician** /Medical Due to (or as a consequence of): Examiner Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Tes 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident

Division or Vital Records, P.O. Box 68760 or Attending Physician: I Director: / completely filled in by within 24 hours a To the Funeral I

6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

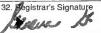
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D0026183

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

North EAST, Md E. Cecil Auc.

State Registrar 31. Date filed (Month, Day, 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10:30 p<sup>M</sup> Maido Kari July 2, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours 1 XM 2 ☐ F 215-30-9021 Feb. 14,1934 Estonia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Maryland Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 24129 Newbury Road 20882 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No 1953~ If Yes, Give Year or Dates: 1956 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 1956

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

(Give kind of work done during most of working life. DO NOT use retired)

Fort Lincoln Crematory July 12, 2007

22. Name and Address of Facility

<u>Procurement Specialist</u>

16b. Kind of Business/Industry

20c. Location - City or Town, State

Simple Tribute, 1040 Rockville Pike, Rockville, MD 20852

Brentwood, MD

18. Mother's Name (First, Middle, Maiden Surname)

Vera Masso

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

24129 Newbury Road, Gaithersburg, MD 20882

Department of Energy

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural"; or items 23a or 28a-f show
any Injury or other traumatic event, the Medical Examiner must be notified at
once.

**Physician** 

/Medical

Directo

Funeral

ģ

Completed

Be

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+) 5+

3 Removal from State

Elementary/Secondary (0-12)

Handu Kari

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

1 ☐ Burial 2 X Cremation

21. Signature of Fundal Service

4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type. Print)

Maria Pedak-Kari- Executor

Examiner

**Funeral** 

Director

Physician /Medical Examiner

ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

shock, or heart failure. List on	ly one cause on each line.					Interval Be	
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia Due to (or as a conse	quence off:				Onset and	Death
	h	quotise 51/.					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause University of Figure 1997.	Due to (or as a conse	quence of):					
that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □Ectopic	c pregnancy (specify)		23d. Date of de Month	elivery Day	Year
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e. Did tobacc	co use contribute to	o the cause of	death?
				1 ☐ Yes	2 No 3 P	robably 4 🔀	JUnknowr
				24a. Was an autopsy performed 1 Yes 2 √2	?   death?	utopsy findings completion of o	available cause of
25. Was case referred to medical			26. Place of De	eath (Check only one)			
examiner? 1 □ Yes 2 □ No	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecity)	
27. Meaner of Death 1 Natural 5 Pending 2 Accident investigati		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	njury occurred		
3 ☐ Suicide 6 ☐ Could not determine	be d 28e. Place of injury - At h building, etc. (Spec.	nome, farm, street, factify)	tory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Nur	mber,
29a. Certifier (Check only one) 1½ CertifyIng I 2 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death occurr action and/or investigat	red at the time, date and plaction, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause	(s)
29b. Signature and title of certifier		:	29c. License number	29d.	Date signed (Mon	th, Day, Year)	
- War	Mv0		D0054566	Jul	Ly 6, 200	)7	
30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type, Print)					

State

Registrar

31. Date filed (Month, Day,

Year)

JUL I U 2007

Sunitha Bhogavilli, M.D., 14702 Cherryleaf Terrace, Silver Spring, MD 20906

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 09:39 AM Ju<sub>1y</sub> 2007 Krupsaw 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Montgomery

9. Birthplace (State or Foreign Country) Montgomery General Hospital . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 81 Yrs. Director 579-22-9648 09/12 /1925 Washington DC Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ir then "natural", or items 23a or 28a-f show the Medical Exempler must be notified at 1 ☐ Yes 2 XNo Director Montgomery Colesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 824 Snider Lane 20905 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No Army If¥es, Give Year or Dates: ₩₩2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: ģ Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Retail Bedding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 is marked ott 2 Louis Krupsaw Mary Silverton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 Snider Lane Colesville MD Charles Krupsaw- Nephew 20905 or other 20b. Place of Disposition (Name of cometery, crematory or other place)
King David
Memorial Gardins 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State sertment of 4 ☐ Donation 5 ☐ Other (Specify) 7/10/2007 Falls Church VA permit.
Departn
Imports
any nju 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Edward Sagel Funeral Direction INC. 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAV a. HTHEROSCLEROTIC /Medical Due to (or as a consequence of): Examiner be Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Igned by the attending physicien and be deteched for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes certificete 2 No 1 ☐ Yes After this certific funeral director. 25. Was case referred to medical examine?

1 os 2 No Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PR/Outpatient Certification; To 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death
To the Funerel Director;
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 To the Hospital of within 24 hours of To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10030414 30. N me d address of person who complete cause of death (Item 23a) (Type, Print) PRINCE PHILIP DR. OLNEY 20832 HERRI 31. Date filed (Month, Day, Year)

JUL 10 32 Registrar's Signature State Registrar

		For State Registrar		<b>se Type or Pri</b> State of M		d/D	epart		lealth and	_		200	7 237	7
Physicia /Medic	_	1. Decedent's Name		Last) Lan Kenned	2.6					2. Date of De Month	eath Da			M
Examin Funeral			f not institution, L. HOSPT'	give street and number			hday)	b. City, Town, o  CUMBER f Under 1 Year flonths Days	LAND If Under 24 Hr. Hours Mir	s. 8. Date of Bi	rth ay, Year)	ALLEGAL 9. Bi	ath  NY  Inthplace (State or Fore Country)	ign
Director		Usual Residence of 10a. State				-	or Locat	ion		1-28-	-195	5   1	M D  10d. Inside City Limit	its
ith the Mary or 28a-f sh e notified	Director	PA 10e. Street and Nu	mber	erset	Ну	yndm		10f. Zip Code			_	tizen of What C	1 □ Yes 2 📶	<b>No</b>
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	282 Bi  11. Marital Status 1 □ Never Marr 3 □ Widowed		12. Was Deceden Armed Forces	? No	.S.		15545 s Decedent of Hes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or N erto Rican, etc.)	us o-	14. Race - Am Black, Wh Specify: W	ite, etc.	
within 72 hou ene than "natura he Medical E	Completed	(Spec	ondary (0-12)	s Education t grade completed)  College (1-4or	5+)	ī., .	(Give kin life. DO	it's Usual Occup id of work done NOT use retire	during most of w d)	orking		ind of Busines	s/Industry Store	
uld be filed Mental Hygi Irked other Itic event, t	To Be Co	17. Father's Name	(First, Middle, L	.ast) 1ce Carde	r	1	_3.4.1	es ca	18. Mother's Na	ame (First, Middle	e, Maider		32076	
and 2 sho lealth and Pealth and P			S. Ker	ip (Type. Print) INELL/HUS I		2 8	82 E	Bingo 1	Farm Rd	Rural Route Numi	dman		15545	
permit. Pages 1 Department of F Important; If ite any injury or ot once.			☐Cremation 5☐Other (Sp					on <i>(Name of</i> tory or other pla <u>CM eter l</u> lame and Addre				,	n, PA Funeral	
Physician peath certificate be executed /Medical Examiner attending physician and for use as the burial-transit	ical Examiner	as Part1. Inter is shown or hea immediate Cause disease or condition resulting in death)  Sequentially list could any, leading to in cause. Linter Unde Cause (Disease or that initiated events resulting in death)	art failur I./ List of (Final onditions, nmediate criying injury s	a. MYOCARD Due to (or a  c	Ine.  I AI T is a conseq is a conseq	NFAH uence o	R <b>CTI</b> ( f): f):						Interval Between Onset and Death	
the death certific y the attending p	Physician/Medica	iF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 🗆 Feta	al death		ctopic pregnanc tther (specify) _	у			23d. Date of d Month	elivery Day Year	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Completed by Ph	-		ns contributing to death , TOBACCO A		-			ven in Part I.	1 <b>\</b>	Yes 2 s an opsy formed?	24b. Were prior to	to the cause of death?  Probably 4 Unknot  autopsy findings availal  completion of cause of	wn
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	on: To Be	25. Was case referexaminer?  1 Yes 2  27. Manner of Deat  1 Natural	No th 5 □ Pending		ijury	ER/Out 28b. T	·	28c. Inju Wo	ner: 4 □ Nursing ry at rk?	Home 5 Res	sidence		pecify)	
ai or Attend s after death. ai Director: / ed in by the f	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigi 6  Could n determin	ot be 28e. Place of i	njury - At he etc. <i>(Specit</i>		m, stree	M 1 □	Yes 2 No		(Street ar own, State		Rural Route Number,	
the Hospit hin 24 hours the Funera npletely fills	edical	29a. Certifier (Check only one)	2 Medical E	g Physician: To the bes Examiner: On the basis and manner	of examina	owledge, ation and	, death o	ccurred at the ti stigation, in my 29c. Licens	opinion, death oc	ce, and due to the	e, date an	nd place, and d	ue to the cause(s)	
2/3	M	29b. Signature and	Im	who completed cause of	death (item	n 23a) [	Tyne Pri	DC	0054004		290. Da	signed (Mo	nth, Day, Year)	
アルム Sta Registr			KHANNA	1221-E NA		L HI	GHWA	Y, LAVA	ALE, MD	2150	2			

		1 - For State Registrar					artment of F			Reg. No.	JAJ 1	23780
Physici /Medic		1. Decedent's Name		, Last) W.		LOVE			2. Date of Dea	ath Day 9	Year 2007	3. Time of Death  11:30 A <sup>M</sup>
Examin		4a. Facility Name (II	f not institution,	give street and n	umber)		4b. City, Town, o	r Location of Death	\ <u></u>	4c. Cour	nty of Death	
		ATLANTI	C GENE	RAL HOSP	LTAL		BERI			WOF	RCESTE	
ineral rector				6. Sex 1 □ M 2 🖾 F			Months Days Hours Min		8. Date of Birt (Month, Da OCT • 12	v. Year)	COU	lace (State or Foreign htry) IARYLAND
<b>*</b>		Usual Residence of 10a. State	Decedent 10b. County		10c, City	, Town or Lo	cation				1	0d. Inside City Limits
imporant: if item 2.1 is marked other than "hatural, or items 2.3s of 28s-1 enow eny injury or other traumatic event, the Medical Examinar must be notified at once.	ō	MARYLAND		CESTER	TER WHALEY							1 X Yes 2 □ No
Illor	Director	10e. Street and Nur		JEDIEK	10f. Zip Code		10g.		10g. Citizen o	Citizen of What Country?		
2	<u>e</u>	11717 SH	HEPPARDS	CROSSI	NG ROAD		2187	21872		US	USA	
9	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced		12. Was De	1 ☐ Yes 2 🕅 No If Yes, Give 1		Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	res or No- 14. Race - / n, etc.) Black, V		
	y.			ed 1 Tyes			1□Yes 2X No	Specify:	, ,	Specify		
	d by	3 M Widowed			Year or Dates:		dent's Usual Occup			WHITE		
	lete			grade completed	(Give			during most of work	ing	16b. Kind of Busine		dustry
	Completed	Elementary/Seco	ondary (0-12)		College (1-4or 5+) 4 REG		SISTERED NURSE			HEALTH		ARE
	0	17. Father's Name (First, Middle, Last)				18. Mother's Name			(First, Middle, Maiden Sumame)			
	To B	WALT	Ρ.	WHALEY		JOSEPHINE		DALE				
	Ċ	19a. Informant's Na	ame/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	and Number or Run	al Route Numbe	er, City or Tow	m, State, Zip	Code)
		FRANKLIN		/E/SON	1			WHALEYVII				
20		20a. Method of Disp 1 X Burial 2 [		3 □Removal from		ace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location	n - City or To	own, State
,		4 Donation	5 Other (Sp	ecity)	I .	ALE CE		7/14/	/07	WHALE	YVILL	E, MARYLANI
ouce.		21. Signature of Fu	ral Service L	icensee	7		. Name and Addre	,				
o a		(M	ulyh	Hux	1			FUNERAL HO			E, DE	
		23a. Part Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.								Approximate Interval Between Onset and Death		
II)		Immediate Cause ( disease or condition resulting in death)	(Final on	a			vacidos i	3				
al er		, and a second		Due to	o (or as a consequ							
	- a	Sequentially list conditions,  b. Lactic ac-losis  Due to (or as a consequence of):										
Ŧ	듣	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events  c.										
	Examiner	that initiated events c							-			
	-E			d								
	ed											
	Physician/Medic	IF FEMALE: 23b. Was decedent			utcome of pregna birth 2 Petal		Ectopic pregnancy	,			Date of delive	,
	sicis	in the past 12 1 □ Yes 2	≸No	4□Pre	gnant at time of de		Other (specify)	'		•	Month	Day Year
	Phy		9 □ Unknown 9 □ Unknown									
	þ	Part II. Other significant conditions contributing to death but not resulting in the				-	nderlying cause giv	en in Part I.	1	obaccouse co Yes 2 ⊡ No		ne cause of death?
91	eted	Drahetes Stroke								7 05 2   NO	3 - 100	Jabiy 4 (Applicational)
,	Completed	Hyp.	rtension	1					24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
			nentia							rmed? 20€No	death?	2 No
	Be	25. Was case reference examiner?		Hospital: 👟			t all DOA Oth	26. Place of Deat				
	5	1 Tes 2 X			Unpatient 2  e of Injury	ER/Outpatien 28b. Time of	I 3 DOA	4   Nuising Ho	me 5 Residence 128d. Describe I			y)
1	tlon	1 Natural 2 Accident	5 Pending investig	(Mo	пth, Day Year)	Injury	Wor	k? Yes 2 □ No		,, 000		
compretely lined in by the furiellal director, page a should be detached for use as the	flca	3 Suicide	6 ☐ Could n determi	ot be 28e. Plac	e of Injury - At ho						mber or Rura	Al Route Number,
	Certification;	4 🗌 Homicide	30(0)(111		ding, etc. (Specif)		,		City or Tov	vn, State)		
	edical C	29a. Certifier (Cireck only one)	1★ Certifying	xaminer: On the	ne best of my kno- basis of examinat inner stated.	wledge, death ion and/or in	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as s e, and due to	tated. o the cause(s)
	Mec	29b. Signature and	title of certifier	anu ma	anior stated.		29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
. 1		Man		mala,	N/C		ILA	06442		7	09/2	•
D				CIA A X AL	1 1 1 1		137/	11017	×	/ /		/
D		30. Name and addre	ess of person	to completed ca	use of death (Item	23a) (Type	Print)	001.0	0	' /		-
psDV		30. Name and addre	ess of person	completed ca	use of death (Item 733 Heult	23a) (Type,	Print)	in, Many lon	ad 2181	11		

Registrar DHMH 17 Rev 1/2001 JUL 1 0 2007

Baltimore, Maryland 21215-0036

55: 210-14-8621

1301: 10/12 | 1913 DOL 01/09/2007 100: 1130

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar		epartment of Health and <b>i</b> Certificate of Death		g. No.	20101	
Physicia		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death	
/Medica Examine		William Harry Lowe 4a. Facility Name (If not institution, give street and	4b. City, Town, or Location of Death  Boonsboro	July	9 2007 4c. County of Deat	12:15PM ton County		
Funeral Director		19420 Roxbury Road  5. Social Security Number  143-34-0703  6. Sex 15 M 2	F 63 Yr	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, June 1	9 Birt	nplace (State or Foreign untry)  W Jersey	
Maryland f show		Usual Residence of Decedent  10a. State 10b. County  Maryland Washington	ington Boonsboro				10d. Inside City Limits 1 ☐ Yes 2X No	
th with the 23s or 28e	בֿ	10e. Street and Number 19420 Roxbury Road		10f. Zip Code 21713	10	og. Citizen of What Co U.S		
3 s	by Fur	1 Never Married 2 Married 1 Never Married 1 Ne	Decedent Ever in U.S. d Forces? /es 2 \( \) No ;, Give or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: Wh.	e, etc.	
d within 72 hours af gene. Than "netural", or than "netural", or than "netural", or the Medical Evaluation of the medical Evaluation of the Medical	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12)  Colle	ted) 16a. D (() () () () () () () () () () () () ()	ecedent's Usual Dccupation Give kind of work done during most of wor de. DO NOT use retired)  President	rking	16b. Kind of Business/ Printing	,	
d 2 should be filed at any and a should be filed at any and a should by a strength at a should be filed at a should be should	To Be C	17. Father's Name (First, Middle, Last)  Harry Lowe	E	18. Mother's Nar	ne (First, Middle, Mannie Vano)	lst Lowe		
and 2 sho lealth and im 27 is m		19a. Informant's Name/Relationship (Type, Print Anita Lowe - wife		Mailing Address (Street and Number or Ru 19420 Roxbury Road Disposition (Name of	Boonsbor		21713	
DESILLINGTE, Descript. Pages 1 a Department of Hee Important: if Item any injury or othe	r	20a. Method of Disposition  1 ☐ Burial 2 X Cremation 3 ☐ Removal 1  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	rom State cemetery,	crematory or other place)	1-07	Smithsburg	Maryland	
Dermi Permi Depa Impo Impo	1	23a. Part 1. Enter the disease, of complications shock, or heart failure. List only one cause	hat caused the death. Do no	1331 Eastern Blvd.	N. Hage:	rstown Mar		
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Proskte e to (or as a consequence of)	Concer			Onset and Death	
	Examiner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury)						
ificate be executed g physicien and as the buriel-transit	edical Exa	that initiated events resulting in death) Last						
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Mec	in the past 12 months?	s, outcome of pregnancy ive birth 2 □ Fetal death tregnant at time of death Inknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year	
w requires that the sheet signed by should be detailed	6	Part II. Other significant conditions contributing	to death but not resulting in t	he underlying cause given in Part I.	1	o. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2.☐ No 3 ☐ Probably 4 ☐ Unknown		
The law re	Completed				24a. Was an autops perform	y prior to death?	utopsy findings available completion of cause of	
ysician: ysician: is certific director.	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outp	104	ath (Check only on	e) ence 6 □Other (Spe	cify)	
To the Hospitel or Attending Physician: The law requires takin 24 hours after death.  To the Funeral Director: Alter this certificate has been signs completely filled in by the funeral director, page 2 should be	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be 28e.	ne of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe ha	be how injury occurred on (Street and Number or Rural Route Number,			
To the Hospitel or A swithin 24 hours after To the Funeral Dire completely filled in by								
the He	Medical	(Check only one) 2 Medical Examiner: On and 29b. Signature and title of certifier	manner stated.	29c. License number		ed at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)		
A		Michael M	elsonal A	0 4/1/-		7.10.	07	
10		30. Name and address of person who completed  Michael McCo  31. Date filed (Month, Day, Year)	cm = ck ////	10 Melsol 1	mrs	Hasento	an mo	
Stat Registra	e ir	31. Date filed (Month, Day, Year) JUL 133 2007	32. Registrar's Signature	Mars.				
DHMH 17 Rev 1/20	01			IIGINAL				

			1 - For State Registrar	State of Many	•	artment of H		d Mental Hy	giene Reg. No.	2007	2378			
	Physici /Medic		Decedent's Name (First, Middle, Last)	Anne Lea L	0K0S			2. Date of De July 9,		7 Year	3. Time of Death 5:30 P м			
a.	Examin		4a. Facility Name (If not institution, give s 12419 Sky Blue Dr	rive		4b. City, Town, o German	town		N	oc. County of Death Montgomery				
	Funeral Director		5. Social Security Number 578-24-2620  Usual Residence of Decedent		n yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bir July 10	<sup>th</sup> , Yell'92	9. Birthp 25 Wash'i	ngton, DC			
	e Maryland la-f ehow tiffed at	ctor	10a. State 10b. County Maryland Montgomer		German					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	uth with th	rai Dire	10e. Street and Number 12419 Sky Blue Dr	rive		10f. Zip Code 208	874			en of What Cour ed State				
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: if item 27 is marked other then "natural", or items 23s or 28s-f show vary injury or other treumatic event. The Medical Examinar must be notified at another.	d by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No ento Rican, etc.)	)- 1·	4. Race - Americ Black, White, Specify: Whit	etc.			
Baltimore, Maryland 21215-0036	d within 72 hogiene. In then "natu	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0·12)		(Give	dent's Usual Occup kind of work done DO NOT use retired retary	during most of 1	working		of Business/Ind Dunting	dustry			
/land	uld be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Nathan Wiener	`				Name (First, Middle a Richter		Sumame)				
, Mar	and 2 sho ealth and in 27 to m		19a. Informant's Name/Relationship (Ty, She1don B. Lokos,	Husband			and Number or e Drive	, Germant	er, City or COWN,	TOMB. State Zig	74°			
timore	Pages 1 tment of H tant: If ites	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Menorah G	natory or other plac Sardens	07/	Date 11/07	Rock	ation - City or To				
Ba	Depar Impor eny in		21. Signature of Fun ral Sarvice License		<b>&gt;</b> 25	4 Carrol	1 St.,	Funeral NW, Washi	ngtor	n, DC 2	0012			
1	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ne cause on each line.	Can (	er the mode of dyin	ig, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death			
68760,	icate be executed physician and s the burial-transit	edical Examiner	causes. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of);									
O. Box	The law requires that the death certific ste hes been signed by the attending p page 2 should be detached for use as	2	wsician/M	hysician/M	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 ☑No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	′		23	3d. Date of delive Month	ery Day Year
rds, P.	w requires that been signed I should be det		Part II. Other significant conditions con				obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Profixnown		/					
Vital Record		Completed								prior to co death?	psy findings available mpletion of cause of			
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7	Physician: this certific ral director,	မ	1 ☐ Yes 2 ☑ No		2 ER/Outpatier		4 🗀 Nursin	g Home 5 Thesi	dence 6	Other (Specif	y)			
Division of	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Certification:	27. Manner of Death  1 PNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye		M 1	y at k? Yes 2 □ No	28d. Describe						
<u>&gt;</u>	pital or At urs after o eral Diraci		4 Homicide determined	28e. Place of Injury building, etc. (S	Specify)			City or To	wn, State)		I Route Number,			
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one)  2 Medical Examination  29b. Signal free and title of certifier	sician: To the best of more: On the basis of example and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	pinion, death or	ace, and due to the ccurred at the time,	date and p	and manner as solace, and due to signed (Month,	the cause(s)			
)	1 <u>0</u>		Descrie Wood	Stevsti	my	Doo		5	7/1	0/07	7			
	V		30. Name and address of person who co Geneviewe Wrob!  31. Date filed (Month, Day, Year)	empleted cause of death  EWS Ci. Mi.  32 Registrar's	1355	Piccard	Driv	e Roc	Kuil	le mo	20857			
	Sta Registr		111 1 0 200	7 Angistial's	K A	See P								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 5, **Physician** 2007 12:59 A M Shirley G. Levin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, You Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 5. Social Security Number Year, Months Days **Funeral** Hours 1 □ M 2 🔀 F 1922 Maryland 84 **Director** 577-24-8047 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1, Yes 2 No Director Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20814 USA 5450 Whitley Park Terrace, #510 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Specify: 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Cohen Bennett Golomb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 5450 Whitley Park Terrace, #510 Bethesda, MD 20814 Sam Levin-Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns JULY 8,2007 Olney, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee 1091 Rockville Pike Doma Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Clostridium Due to (or as a consequence of): Sequentially list conditions, Jate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar the ģ

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. ours after death. leral Director: After this certific filled in by the funeral director,

To the Hospital within 24 hours a To the Funeral C

ical Ex	resulting in death) Last	Due to (or as a consequence of):	
Physician/medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 12 No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
2	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobat 1 Tyes	acco use contribute to the cause of death?  3 □ Probably 4 □Unknown
Сотріете		24a. Was an autopsy perform	ed? death?
De C	25. Was case referred to medical	26. Place of Death (Check only one	)
0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 2 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resider	nce 6 Other (Specify)
	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work? 1 Yes 2 No	v injury occurred
Certification:	3 Suicide 6 Could not 4 Homicide determine		eet and Number or Rural Route Number, State)
Medical C	29a. Certifier (Check only one)  1 Certifying F 2 Medical Ex	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cauminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, day and manner stated.	ite and place, and due to the cause(s)
Me	29b. Signature and till a confifer	29c. License number 29	d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

*2*0850

DR. ATUL ROHATGI, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 0 2007

31. Date filed (Month, Day, Year)

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2007 0045 July /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Clinton
If Under 1 Year | If Under 24 Hrs. Southern Maryland Hospital Prince George's 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🕅 F Director Mar. 3, 1924 Wash. DC 578-26-0733 10c, City, Town or Location 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 TyYes 2 ☐ No Suitland [ ] Director Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 United States 3940 Bexley Place, #701 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give <sup>1</sup>⁄⁄⁄
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Custodial Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agnes Parker Harvey Lee, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma A. McNeal/Sister 3208 Dallas Drive, Temple Hills, MD 20748 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 7/13/ 2007 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 eul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, otheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** semic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2[] N 2 ER/Outpatient 3 DOA 1 Depatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident **Director:** 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier ۲ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

UZ (5)

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #5, perFH,0869, 7/26/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <sup>Month</sup>/09/ั2007 Bertha Kohn 6:25 AM Lee /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F 61 266-78-<del>8137</del> 12/06/1945 Florida Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mind handled. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 ☐ No Director PGMD Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4301 23rd Parkway #608 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2√∑ No Specify: Specify: Black Ş Q 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fed. Gov't Accountant 4 vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Billy Artis Minnie Kohn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 225 Hazelmere Drive; Holly Springs, N.C. TauFiki E. Lee - Son 27540 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/14/2007 Clinton, Maryland Resurrection Cem. 22. Name and Address of Facility
Freeman Funeral Services
7074 21. Signature of Funeral Service Licensee 4594 Beech Road; Temple Hills, MD 20748 23a. Part1, tinter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Colon Cancer with metstatists lung Klive disease or condition resulting in death) Unknown Advanced /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed certificate or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Subacute Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury 28b. Time of 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

W (8)

State Registrar 31. Date filed (Month, Day, Year) JUL 1 1 2007

ROINTAN

FARAHIFAR M.D. 9801 Georgia Ave suit 3-41 Silver spring MD 20902

(ear) Segistrar's Signature

1. Special

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43446

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			For State Registrar	State of Maryland / Dep	eartment of Health and I	Mental Hygiene	2007 23787	
			1. Decedent's Name (First, Middle, Last	)		2. Date of Death Morith Day	3. Time of Death	
	Physici: /Medic		SUN YOUNG	LEE		July 9th	1207. 445AM	
	Examin		4a. Facility Name (If not institution, give BALTIMORE WAS		Glan Burr	798 17	county of Death	
	Funeral Director		213 30 3302	X 7. Age (In yrs. last birthday 86 Yrs.	Months Days Hours Min.	(Month, Day, Year)	9. Birthplace (State or Foreign Country) 921 S KOREA	
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I			10d. Inside City Limits	
	Marylan -f show	ţō	MD ANNE ARI	UNDEL SEVER	N		1 ☐ <b>Y</b> es 2 ☐ No	
	with the Mi 3s or 28s-f	Funeral Director	10e. Street and Number 8145 SILO RD		10f. Zip Code 21144		ten of What Country? KOREA	
36	be tited within 72 hours after death with the Maryland Hygiene.  Id either then "natural", or items 23s or 28s-f show do other then "natural", or items 23s or 28s-f show event. It is Medical Examinar must be notified at		11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ★ No Specify:	o Rican, etc.)	Race - American Indian,     Black, White, etc.  Specify: ASIAN	
21215-0036	within 72 houene. ene then "nature	Completed by	15. Decedent's Edu (Specify only highest grad	de completed) (Giv   College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	nd of Business/Industry	
C	filed w Hygier ther th		12. Father's Name (First, Middle, Last)	4 PRC	PRIETOR	me (First, Middle, Maiden	OCERY	
and	ould be fit Mental H Marked ott	Be			HUN		KIM	
Maryland	2 should be fited within and Mental Hygiene. Is marked other then aumatic event, Ite M	ဥ	JUNG SIK LEE  19a. Informant's Name/Relationship (T)	ype, Print) 19b. Ma	ling Address (Street and Number or Re			
	and 2 : ealth ar n 27 is her trau		JULIANNE KIM/D	AUGHTER 814	5 SILO RD SEVE	RN MD 2114	4	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny injury or other traumatic. ong.e.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Hemovai from State	ematory or other place)	1 3 / 27	cation · City or Town, State  LTIMORE MD	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Livins	see S	22. Name and Address of FacilityCH.	ARLES HIND	S FUNERAL SERV.	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,						Approximate fritervaf Between Onset and Death	
68760,	titicate be executed by titicate be executed by physician and as the burial-transit	ical Examiner	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d				
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		DEctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
٩	uires that t signed by Ild be deta	Þ	Part II. Other significant conditions co	ontributing to death but not resulting in the	underlying cause given in Part I.		se contribute to the cause of death?	
Records,		Completed			<del></del>	24a. Was an autopsy performed? 1 ☐ Yes 2 5 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 No	
Vital	cian: ertific actor.	Be	25. Was case referred to medical examiner?	11		ath (Check only one)		
of	Physician: this certific ral director.	ဥ	1 ☐ Yes 2 ☐ No 27. Manner of Dea h	Hospital: 2 ER/Outpat		lome 5 Residence 6		
no	ding P. After funer	tion	1 Natural 5 Pending	(Month, Day Year) Injury		200. Describe now injury	y occurred	
Division	l or Attending after death. Director: After I in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Street and City or Town, State)	et and Number or Rural Route Number, State)	
_	e Hospital 124 hours a e Funeral I letely filled	Medicai C		vician: To the best of my knowledge, de hiner: On the basis of examination and/or and manner stated.				
)	To th within To th comp	Me	29b. Signature and title of certifier	S, MD	29c. License number	29d. Dat 07	e signed (Month, Day, Year)	
2_	2		30. Name and address of person who of	completed cause of death (Item 23a) (Typ	e, Print) Hospita	m) Dr. (	5 len Burnit, m	
	Sta Regist	ate rar	JUL 1 1 2007	32. Registrar's Signature	<i>V</i>		<u> </u>	

Amended #15, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06/18/07, Allegany Co. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 15 Year **Physician** Lois Layton 06 1245 p <sup>M</sup> /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany WMHS Braddock Campus If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 2 F Months Days Hours 212-24-2292 76 Director Maryland November 05, 1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. Cify, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 No Director Maryland Allegany Frostburg 10e. Street and Number 100 Honeysuckle Lane 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. 14. Race - American Indian, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 textile seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John T. Myers ပ္ Margaret Rayner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Ann Preston 14807 Woods Edge SW Co Cumberland Daughter Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) June 18, 2007 Frostburg Maryland 21. Signature of Funeral Service 22. Name and Address of Facility John 7 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RUPTURE Immediate Cause (Final disease or condition resulting in death) ABDOMINOZ HORETIC Hredaysm **Physician** Hour /Medical Due to (or as a consequence of): **Examiner** Horarc AB DomiNAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed ATHEROSC UEILOTIS the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HUPERASINSIN 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Man of Death 1 Natural 28c. Injury at Work? To the response after death.

To the Funeral Director: After the Funeral Director of the funeral part of t 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 3

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Registrar

Tred Erckson
31. Date filed (Month, Day, Year)

JUN 1 8 2007

D Seton Drive 9. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CumberLAND,

MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician July 14, 2007 12:00 PM M Mary A. Leptic /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg 11434 Upper George's Creek Road Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 X F 215-12-2485 84 Maryland Director January 14, 1923 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Allegany Frostburg Maryland death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11434 Upper Georges Creek Road U.S.A 21532-Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify. Specify. þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) housekeeping dept. state university 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Charles Seggie Pearl Whitehead ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532daughter Maryland Linda Leptic 11436 Upper George's Creek Road Frostburg injury or other Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Frostburg Memorial Park Frostburg Maryland July 17, 2007 21. Signature of Funeral Service Licer 22. Name and Address of Facility ohn K Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Umour Physician month vam /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 hot To the Fune completely fi 10

noss State Registrar

Sand 31. Date filed (Month, Day, Year) 7 2007 JUL 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



48 Tarn Terrace, Frostburg, Maryland 21532

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July 08, 2007 Physician 08:50 AM M William Birch Livingston, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg 9 Grant Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** (Month, Day, Year) November 22, 1919 Months Days Hours 1 MM 2□ F Maryland 218-10-4278 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 MYes 2 □ No Frostburg Maryland Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 Grant Street 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW 1 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) owner 0 welding and fabricating 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hisant: If item 27 is marked oth Christine Ethel Eisler Chalmer Neil Livingston ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21532-9 Grant Street Frostburg Maryland Ruth Livingston wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Frostburg Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h Important: If ite any Injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State Maryland Frostburg July 11, 2007 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intractale. 08TIUE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 4 Jans many Examiner dio myo 30 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen of): Examine the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day in the past 12 months? ned by the a □Yes 2□No 9 Unknown The law requires that signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 1/No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed yes 2 No has certificate 1 Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Presidence 6 □Other (Specify) ို 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Certification: Injury (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar

CHANG M.D SATURNINA 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

BROA DWay

29c. License numbe

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician MacARTHUR** 13 SHIRLEY G. 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MEDICAL Wicamico LENTER ALISBURY ENINSULA KEGIONAL Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours 1 □ M 2 🛣 F 76 04-27-1931 Delaware Director 222-18-6634 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County 23a or 28a-f show 1 ☐ Yes 2 No Seaford Sussex Examiner must be notified Directo Delaware 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19973 US 4686 Briar Hook Rd Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: white \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Roberts Theodore Gleason 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4686 Briar Hook Rd, Seaford, DE 19973 Maurice MacArthur - husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Odd Fellows Cemetery Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 07/10/07 Seaford, DE 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility
Cranston Funeral Home 21. Signature of Funeral Scrvice Licens ohn A. efanston. P O Box 967, Seaford, DE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE STERM OREAN FAMULE **Physician** ( WEEK /Medical Due to (or as a consequence of): Examiner REPLEMENTS MARA AND ZUKS 277C Securitically list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 4 Unknown 2 🗌 No 3 Probably 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 TYes 2 No 1☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 2 Accident completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of JUL 06 2057 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY Md 21801 Todd MD CARROLL ST. JAMES 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL

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			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physici /Medic	_		orge	McCab			July	8 200	77 18:10 M
	Examin	er	4a. Facility Name (If not institution, give street and r				Location of Death	,	4c. County of E	
-		ei.		7. Age (In yrs. last		der 1 Year	If Under 24 Hrs.	8. Date of Birt		MICO Birthplace (State or Foreign
B	Funeral Director		144-26-2424 900-31-4473 10 MM 2□F	74	Month		Hours Min.	(Month, Day	y, Year)	Country)
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location					10d. Inside City Limits
	Mary f sho	tor	DE Sussex	Mi1	Lford					1 □ Yes 2 <b>X</b> □ No
	h the	irec	10e. Street and Number			Zip Code			10g. Citizen of Wha	t Country?
	th wit 23a o 1st be	Funeral Director	2432 Thompsonville Road	d		1996	3		USA	
	r dea ems er mu	ner	Armed	ecedent Ever in U.S. Forces?	13. Was Dec	cedent of Hi pecify Cuba	spanic Origin? (Spen, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 1 ☐ Yes or 1 ☐	3 2□No 1951 Give Dates: 1952	- 1 DV00	2 <b>∑</b> No	Specify:		Specify: V	
5-0	72 ho 'natu dical	etec	15. Decedent's Education (Specify only highest grade completed		6a. Decedent's U	sual Occupa work done o	ation luring most of worki )	ng	16b. Kind of Busine	ess/Industry
121	within ene. than "	Completed	, , ,	(1-4or 5+)			)		0.16.5	
	e filed val Hygie other i		17. Father's Name (First, Middle, Last)		Salesm	ian	18. Mother's Name	(First, Middle,	Self-Emp Maiden Surname)	loyed
au	ld be ental ked o	То Ве	Joseph	McCabe			Annie		Hickman	
Maryland	should be and Mental s marked umatic ev	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailing Addre	ess (Street a	and Number or Rura	al Route Numbe	er, City or Town, Sta	te, Zip Code)
	and 2 salth s		Becky Kelley - daughter	1	295 Thom	as St	. Titusvi	lle. FI	. 32780	
ore	es 1 a of He fittern		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal fro	20b. Plac	e of Disposition (A netery, crematory of	Name of	i [	ate	20c. Location - City	y or Town, State
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	50 = # O		The pay be	t aguaged the death.						land 21804
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	The ate his page	E O							rmged/? dea	th? Yes 2 No
/ita	l <b>ysician:</b> Th iis certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only c	one)	
or Vital	y s	은		Inpatient 2 ER			4 ☐ Nursing Ho		dence 6 Other (	(Specify)
		ion:	1 → Matural 5 ☐ Pending (M	te of Injury 28 onth, Day Year)	8b. Time of Injury M	28c. Injury Work	rat :? Yes 2 □ No	28d. Describe I	how injury occurred	
Division	Attending r dea h. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Pla	ce of injury - At home				28f. Location /	Street and Number of	or Rural Route Number,
슬	frer frer i nire	Certification:	4 Homicide determined bu	ilding, etc." (Specify)		•		City or To		
	To the Hospital or Attenwihin 24 hours after death you be the Funeral Director: Completely filled in by the	edical C	29a. Certifier 1 Certifying Physician: To (Check only one) 1 Medical Examiner: On the and m							
	To the within 2 To the	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (f	Month, Day, Year)
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١	1001h		30. Name and ddress of person who completed ca	EAST CARE		SCT				
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DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JULY 5, MARY PATRICIA MARSH 2007 03:20A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs. DECEMBER 48 Director 279-68-3146 OHIO Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL ARNOLD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 495 BAY GREEN DRIVE 21012 UNITED STATES death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene, marked other than SELF-EMPLOYED CONSULTANT ENVIRONMENTAL ADVOCACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F JOHN O'HARA ပ EILEEN O'KEEFE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If item 27 is or other train STEVEN L. MARSH/HUSBAND 495 BAY GREEN DRIVE, ARNOLD, MARYLAND 21012 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. CHESAPEAKE" CREMATION 1 ☐ Burial 2 XCremation 3 ☐ Removal from State JULY 11 4 Donation 5 Dother (Specify) 2007 STEVENSVILLE, MARYL 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM CREMATION AND FUNERAL CARE, P.A. 814 BESIGATE CENTER 21. Signature of Funeral Service Licensee ROAD, ANNAPOLIS, MARYLAND 21401 M00672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 20 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 1□ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

12

State Registrar 29b. Signature and title of certifier

30. Name and address of p

31. Date filed (Month, Day 0 9 2007

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on who completed cause of death (Item 23s) (Type, Print

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

21401

Division or Vital Records, P.O. Box 68760 To the

State Registrar DHMH 17 Rev MIDCH

31. Date flied (Month, Day, Year) 2007

29b. Signature and title of certifier

0. Name and address

32. Registrar's Signature

person who completed cause of death (Item 23a. (Type, Print), 2001

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 5, Physician 2007 Frances Madsen 8:08 A M /Medical a. Facility Name (If not institution, give street and number)
Doctors Community Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lanham Prince Georges If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 579-52-2714 1**X** M 2□F 69 Director Nov 13, 1937 Washington DC Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a or Examiner must be 9602 Dubarry Avenue 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Yes 2 No 1958
If Yes, Give
Year or Dates: 1961 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ρ 3℃ Widowed 4 Divorced White Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Private 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Balla P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank L. Madsen II (Son) 9602 Dubarry Avenue, Lanham MD 20706 item 27 i permit. Pages 1 a
Department of Hee
Important: If item
any injury or othe
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veteran's Cemetery 5 Other (Specify) 7/11/07 Cheltenham, MD 22. Name and Address of Facility Rendon/Hale Funeral Home of Funeral Service License 9013 Annapolis Road, Lanham MD 20706 pri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List one cause on each line. Approximate Interval Between Onset and Death Imp ediate Cause (Final Myocardial infarction Physician ease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe or injury that initiated events Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death signed by the a 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 □ DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year,

State

Registrar

JUL 0 9 2007

31. Date filed (Month, Day, Year)

SUNG



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Guite 306 Lanham. MD 20706

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Marvin C. Marshall 28 2007 7:40 A June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9771 Goodluck Rd., #2 Prince George's Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □XM 2 □ F Yrs. Director 579-50-4109 68 New York Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner received. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9771 Goodluck Rd., #2 20706 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington Gas Elementary/Secondary (0-12) College (1-4or 5+) 12th Inspector Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Marshall Elizabeth Andrew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Marshall/Wife 9771 Goodluck Rd.. #2, Lanham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 7/6/2007 4 □ Qonation 5 □ Other (Specify) Glenwood Cemetery Wash., DC 21. Signature of Funeral Service Lifensee Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., NE Wash., DC 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or andition resulting in Seath) Onset and Death **Physician** Obesity /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes Mellitus Type 2 Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien and the for use as the burial-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □Unknown Be Completed been: 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an 1 ☐ Yes 2 No completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours e To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059633 of person who completed cause of death (Item 23a) (Type, Print) Glen M. Jacob, M.D. 1221 Mercantile Lane, Largo, MD 20774 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of M	laryland / (		nt of H	ealth and	Mental Hy	ygien Reg. N	e n 1 7	23797
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1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-1 ehow the Madical Exemples coulded at	by	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Armed Forces 1	? ]No ETEL TT	13. Was Dece If Yes, spe 1 \( \text{Yes}		spanic Origin? (9 n, Mexican, Puel Specify:	Specify Yes or N rto Rican, etc.)	ło-	14. Race - Ameri Black, White Specify: wh:	, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be titled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 ehow any Injury or other traumatic event, the Madical Examiner must be notified at once.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)	Decedent's Usu (Give kind of w life. DO NOT u )wner	al Occupa ork done d se retired)	ition uring most of wo	orking		Kind of Business/Ir	ndustry
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Baltimore, sernit. Pages 1 ar Department of Heamportant: if Item noy Injury or othe unce.		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 →  4 □ Donation 5 □ Other (Specify	)	•	Disposition (Na ry, crematory or David Me	noria	1 Garde	11/07 n		Location - City or T	
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Physician /Medical Examiner	iner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a Due to (or as	R KIN s a consequence	SONS of):	is or dying	)15 EA	SE	arrest,		Interval Between Onset and Death
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Di To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai	29a. Certifier Certifying Physics (Check only one) 2 Medical Exam	rsician: To the best iner: On the basis of and manner st	of examination an	dor investigation	at the time , in my opi	e, date and plac- inion, death occ	e, and due to the urred at the time	e cause( e, date ar	s) and manner as s nd place, and due t	stated. o the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2007 MCNAIR 25 4:08 P M ETHEL JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY GLADYS SPELLMAN NURSING HOME If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year) Days 1 □ M 2**X**X 71 243-56-5194 SEPT. 30 1935 NORTH CAROLINA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 Yes 2 No Director PRINCE GEORGE'S CAPITOL HEIGHTS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 20743 U.S.A. 335 CARMODY HILLS ns 23a Funeral 14. Race - American Indian items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status "natural", or item ledical Examiner r 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK 6 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the DENTAL ASSISTANT PRIVATE 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any liquy or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY A. HUNT LESLIE HUNT ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 CARMODY HILLS CAPITOL HEIGHTS, MARYLAND 20743 WILKINS MCNAIR SR. /HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State CRESTVIEW MEMORIAL 7/2/2007 HALIFAX, NORTH CAROLINA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atlerosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed Respiratory Failure burial-trar and Due to (or as a consequence of) physician certificate be Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 certificate has performed? 2 No Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 41 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ပ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide 9 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Records,

Division or Vital

31. Date filed (Month, Day, Year) State JUL 1 1 2007 Registrar

29b. Signature and title of certifier

TAHMINA K. AHMED M.D. 831 UNIVERSITY BLVD EAST SILVER SPRING, MARYLAND 20902 32. Registrar's Signatur

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0060100

SUITE 27

29d. Date signed (Month, Day, Year)

JULY 9 2007

			For State Registrar	State of	Maryland	•	irtment o <i>tificate d</i>			lental Hy	giene Reg. No.	0000	
ř			Decedent's Name (First, Middle,)	Last)				-		2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Ruth S. Mus	sselman						July		007	2:50 p м
V-200	Examin		4a. Facility Name (If not institution,		er)		4b. City, Tow		tion of Death		4c.	County of Death	
		e de	Anne Arundel Me	dical Cent	ter		Annap0		ador Od Uro	To B / (B)		ne Aruno	
	Funeral		,	5. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 You Months Da		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign intry)
nd.	Director	}	579-38-3083 Usual Residence of Decedent		78					04/07/	1929	Washi	ington DC
	rland ow at		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Many a-f sh ffied	ğ	MD Anne Ar	runde1	Ann	apolis							1 <b>X</b> Yes 2 No
	th the	Director	10e. Street and Number				10f. Zip Co	le			10g. Citiz	en of What Cou	intry?
	23a ust b	쿌	1070 Cedar Ridg	ge CT			21403					USA	
	tems	Funeral	11. Marital Status	12. Was Decede	es?	S. 13. \	Vas Decedent f Yes, specify	of Hispani Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No Rican, etc.)	1	<ol> <li>Race - Ameri Black, White</li> </ol>	
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2	be filed within 72 hours after death with the Maryland tial Hyglene. id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, La	ast)						e (First, Middle	, Maiden	Surname)	
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	1 and Health em 27 ther t		Kenneth E. Mussel	ıman / Son						napolis		21403 cation - City or T	Town State
Baltimore,	ages nt of h	li	1 🔀 Burial 2 □ Cremation 3		ate		sition (Name on matory or other		1		_		
	it. Partme		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service   i		Lec	lar Hi.	L1 Ceme	tery	Facility Cod	1/2007		land, eral Hor	MD
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	/Medical		resulting in death)	a. Du to (or	r as a consequ	uence of):	alc.Tip	11					
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102	Po #	iner	Sequentially list conditions, if any, reading to initional as cause. Enter Underlying Cause (Disease or injury	Sua tak(a	ras e ounsequ		, ,					- 4	
	recute and I-trans	Examiner	that initiated events resulting in death) Last	c. 2mall	as a consequ		tractiv	1					
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X	death certifi attending I I for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7=				2	23d. Date of deli	very
Division or Vital Records, P.O. Box	Attending Physician: The law requires that the death certif refeath.  ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregna	th 2□Feta nt at time of d		∃Ectopic pregr ∃Other <i>(speci</i> i					Month	Day Year
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ō	Phys r this ral dii	-T	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time o		- 4	☐ Nursing Ho	ome 5 ☐ Res 28d. Describe		Other (Spec	cify)
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/ISI	or Attenceath after death Director: in by the	fica	3 ☐ Suicide 6 ☐ Could no determin	200. Fidue U	of injury - At ho g, etc. <i>(Specif</i>	ome, farm, sti	eet, factory, o	fice		28f. Location	Street an	d Number or Ru	ıral Route Number,
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	So J	2	29b. Signature and title of certifier	0 م ت	-4			182°			7/5	2/2007	, Day, Idai)
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1	- (2)		30. Name and address of person was Reginaldo Lee-I			2000 M	ledical	Park	way An	napolis	,MD	21401	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa				-				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month 1:50 A M 2007 July 02 Frank Leland Norcross /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1**X** M 2□ F 027-14-8304 81 California Director Nov. 03, 1925 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Severna Park 1 ☐ Yes 2 No Anne Arundel Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with **USA** 74 Stratford Drive 21146 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 Divorced Year or Dates er than "natur , the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than Plant Equipment Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret McElheney Arthur Leland Norcross မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 74 Stratford Drive, Severna Park, MD, 21146 Barbara Anne Norcross/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/03/07 Catonsville, MD Metro Crematory 21. Signature of Fundal Service Lice 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 (lens) Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** D15 0 /Medical Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 sl autopsy Yes director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 3□ DOA 1 Inpatient 2 ER/Outpatient this Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, I hours after death.

Uneral Director: A

Certification: To within 24 hours after

To the Funeral Dire

completely filled in b 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ocompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 0 5 2007 31. Date filed (Month, Day, Year) Regist State JUL Registrar **ORIGINAL** 

			For State Registrar	ite of Marylan		irtment of H tificate of I		-	giene Reg. No. 2	107	238	0
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	Funeral Director		5. Social Security Number 6. Sex 215–32–0893	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th 1 927	9. Birthp Coun Mar	lace (State or F itry) yland	oreign
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215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade com		(Give life. L		during most of work I)	ing	16b. Kind of B			
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Baltimore,	e = 5		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Remov	ai irom State		sition (Name of natory or other place	1	Date	20c. Location			
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ם כ	ng Phy fter this			a. Date of Injury (Month, Day Year)	28b. Time of Injury				how injury occu		<i>y</i>	
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	10		) Junk fl	000 / mg		Ma.	1)00/20	36	17/5	107		
	+		30. Name and address of person who comple	ed cause of death (Iten	1	Print) CP	at tom	Med :	17/5, 21620			
	m s Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	1	1. 000		,				
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ı	Physici /Medi		1. Decedent's Name (First, Middle, Last Dorothy E.		schafe	r		2. Date of De Month July	05	Year 2007	3. Time of Death 5:15 A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, given Manor Care Bethes	sda		Beth	r Location of Death		Мо	ounty of Deat	ery
L	Funeral Director		5. Social Security Number 6. S 151-12-4802  Usual Residence of Decedent	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 12/ 23/	y, Year)	Co	hplace (State or Foreign untry) Jersey
	Maryland f show ed at	or	10a. State 10b. County		y, Town or Lo thesda	cation					10d. Inside City Limits 1   Yes 2   No
	with the I a or 28a- t be notif	Direct	10e. Street and Number	<u> </u>	chesua	10f. Zip Code				en of What Co	untry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	6530 Democracy BLV  11. Marital Status  1 □ Never Married 2 □ Married  ★□ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		20817 Nas Decedent of H f Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14	S . A  Race - Ame Black, Whit  Specify: WI	
21215-0036	thin 72 ho e. an "natur Medical I	npleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of work	ing	16b. Kind	of Business/	Industry
	12 should be filled within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Mec	Be	12 17. Father's Name (First, Middle, Last,	)	S	ecretary	18. Mother's Name	e (First, Middle,		nufactu urname)	ıring
Maryland	2 should I and Men Is marker aumatic	2	Frank Svec  19a. Informant's Name/Relationship (	Type. Print)	19b. Mailin	ig Address (Street	Freda and Number or Run	Herbek al Route Numbe	er, City or T	Town, State, 2	Zip Code)
Baltimore, M	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau		Alfred Neuschafer  20a. Method of Disposition  1 Burial 2 X Cremation 3 D  4 Donation 5 Other (Specif	Removal from State	Place of Disponentery, cren	sition (Name of natory or other pla	сө)	Date	20c. Loca	ation - City or	
Baltir	permit. P Departme Importan any Injur		21. Signature of Funeral Service Licer	, na	22		ry ¦ / /l R√f1™ Pi gel Funera		ville	MD 20	
20	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final		h. Do not ente	er the mode of dyi					Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of Acute Rena	uence of):						
	executed n and ial-transit	Examiner	Sequentially list conditions, It also be a conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events the condition of the cause of the condition of the cause of the caus	c. Failure to	uence off: Thrive						
68760,	ate be hysicia he bur		resulting in death) Last	Due to (or as a conseq ⊾d	uence of):						
O. Box	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	il death 3□	Ectopic pregnanc Other (specify)	у		23	d. Date of del Month	ivery Day Year
Δ.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	contributing to death but not resi	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did t			the cause of death?
or Vital Records,	The la ate has page 2	Completed						24a. Was autor perfo		24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of
Vita	i <b>clan</b> : Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		104	26. Place of Death	h (Check only o	ne)		
	ding Physician:  After this certific funeral director,	on: To	1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending	Hospital: 1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ry at rk?	me 5 ☐ Resident Resi			cify)
Division	or Attenditer death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				Yes 2 □ No	28f. Location (5 City or Tok		Number or Re	ıral Route Number,
	the Hospital of thin 24 hours at the Funeral E	Medical C	29a. Certifier (Check only one) 1 X Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death	occurred at the tivestigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) a date and p	nd manner as blace, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	( )		29c. Licens	se number		29d. Date	signed (Mont	h, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Q

Sayed Elsayyad 9715 Medical Center Drive Rockville MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D62435

July 6, 2007

Division or Vital Records, P.O. Box 68760

nas

State Registrar M. Calk

JUL

1 2 2007

ins MD

500 Memorial

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0730 M MER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner SALi 1 COMICO DENNIS SBUR If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 6. Sex MM 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 219-46-255 CI Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Iteme 23a or 28a-f show Pages 1 and 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygheins and the fleath and Mental Hyghein 4. It fleat the marked other then "ratural, or Items 23a or 28a-1 ehow an it items? I a marked other then "ratural, or Items 23a or 28a-1 ehow any or other Itemmatic event, the Medical Examination and interpretation." 1 Yes 2 No Willanico Completed by Funeral Director 10g. Citizen of What Country? 10f. Zis Code 10e. Street and Number 2180 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) -Dennis Annie 201. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or **4** □ Donati 5 ☐ Other (Specify) EMETER 21. Signature Funeral Service Licepsee 22. Name and Address of Facility BENNIE SABELLA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Examiner The law requires that the death certificate be executed as the burial-transil Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year igned by the atte be detached for 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1 ☐ Yes Division of Vital To the Hospitel or Attending Physician: director. 25. Was case referred to medical examiner?
1 A Yes 2 □ No 26. Place of Death Check only one Medical Certification: To Be Other: Hospital: 1 🗆 Inpatient 4 ☐ Nursing Home 5 X Pesidence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Sescribe how injury occurred 27 Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Thomicide hours after within 24 hours a To the Funerel I etely filled 29a. Curtillar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causals) and manner as stated (Check only one) 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce H50497 30. Name and a dress described who completed cause of death (Item 23a) (Type, Print) Salisbu 0.0 100 E. Carroll 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 9 Registrar 2007

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- Registrar Amend PI (23a-c), PII,25,27,28a-f,perMF, 9870, 18 20 Death

Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17:10 2007 Physician July 4 Elizabeth Leona Pritchard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore Univ. of Maryland Medical Syst If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗙 F Director 216-70-1650 50 Maryland Feb. 10, 1957 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County works 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Dorchester Cambridge filed within 72 hours after death with the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 103 Franklin Street 21613 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify white Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) clerk motel 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h 1 and 2 should be Harvey Gray Rose Spear 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra Health gem 27 ls Sara Pritchard daughter 402 Robbins St., Cambridge, MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 7/6/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. · K.P. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Acetaminophen intoxication with complications** Immediate Cause (Final disease or condition resulting in death) Acetaminophen overdose Physician /Medical Due to (or as a consequence of): 1 wk Examiner Liver Failure CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Heptorenal Syndrome law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death 5 Other (specify) detached the Division or Vital Records, P.O. 9□Unknowr 9 ☐ Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Femur fracture, Cirrhosis 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an autopsy performed?
1□ Yes 2□No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 1 **X**Yes — 2 ☐ N Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No June, 2007 2 XAccident 3 Suicide unk subject fell the f within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide unk unk Hospital 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State Registra

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Rec 2007



38 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Eric 8x 22 S. Greene St. Baltimore, MD 21201

29c. License number

18136

29d. Date signed (Month, Day, Year) July 9, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 0216 A M Linda Piper
4a. Facility Name (If not institution, give street and number) 07 7 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbur Coastel Hospine At The Lake
5. Social Security Number 6. Sex Wicomored If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🕱 F Apr. 13,1945 271-42-9017 62 Ohio Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Maryland Wicomico Eden 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5130 Blue Marlin Drive 21822 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Unknown Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Donut Shop Manager permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 is marked other 1 any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy T. Wells Eva J. Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 7, Eden, Maryland 21822 Mark Phippin/Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Of Delmarva July 8,2007 Delmar, Delaware 21. Sign true of Funeral Service Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Var Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tall Bladder Cencer with metastases to leave, boxes **Physician** 1 yr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considered off Examiner burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been signated by should be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 : certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 일 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760, P.O. Division or Vital Records,

Maryland 21215-0036

Baltimore,

To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death.

4 Homicide 29a. Certifier Medical 29b. Signature and title of certifier 3. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

GREGORIO M. BELLOSO, M. D.: 5302 CHINABERRY DR., SALISBURY, MD ZISO1

Date filed (Month, Day, Year)

32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

gerei Mr.

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

07-07-07

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) o ay **Physician** 200 7 Frovenzano 7 /Medical Emanuel 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Days Hours Director 215-30-8971 6/9/1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Dorchester Hurlock 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U<u>SA</u> 5866 Cloverdale Rd. 21643 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Medical 1 and 2 should be filed withi Health and Mental Hygiene. Forklift Operator Laboratory permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christopher Provenzano Jeanette Cimino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Ann Provenzano/Spouse 5866 Cloverdale Rd., Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State MidShoreCremationCenter 7/9/2007 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Mid Shore Cremation Center, P.O. Box 1464, 2272 Hudson Rd., Cambridge, MD 21613 gnature of Funeral Service Licensee s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a Part1. Enter the disease, or complications shock, or heart failure. List only one cause Pulmonary Disease Immediate Cause (Final Obstructive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons or ence of) Examine ohysician and the burial-transit Due to (or as a consequence of) Physician/Medical been signed by the attending particular should be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 5 Other (specify) 1 Yes 2 No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has le 2 performe this certificate 2 **X**No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient မ 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Box 68760 certificate be P.O. I Records. Division or Vital Physician: death. To the Hospital or Attenct within 24 hours after death To the Funeral Director: in by the

PROVENZAND

5-0036

2121

Baltimore, Maryland

Fimande

5 ☐ Pending investigation 6 ☐ Could not be

determined

3 ☐ Suicide

4 Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Cam Dridge

29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 Byrn Eric J. Widmaier M.V.

State Registrar

filled

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31. Date filed (Month. Day Year 1 0 2007

32. Registrar's Signature

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			Registrer  1. Decedent's Name (First, Middle,	201)		Cel	uncai	e or i	Dealii	21	Date of Death	g. No.	0 1	3. Time of Death	_
	Physici	an									Month	Day	Year		
	/Medic		Ruth Monda  4a. Facility Name (If not institution, g			-	4h. City	Town or	Location of		July	4c. Count	2007	5:30 A <sup>M</sup>	_
П	Examin	er					40. Ony,			Death				Coorcola	
	Funeral		Larkin Chase 5. Social Security Number 6			st birthday)		r 1 Year	Bowie	4 Hrs. 8. [	Date of Birth Month, Day,			George Splace (State or Foreign ntry)	_
П	Director		253-01-6387	1 □ M 2 □XF	102	Yrs.	Months	Days	Hours	Min. (	Month, Day, y 28,	Ye <i>ar)</i> 1905		ntry) eorgia	
	P .		Usual Residence of Decedent							4.10	,	- , , ,			_
	anylar show	-	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits	
	Ba-f	Director		George's				Ca	pitol	Heigh	ts			1∭Yes 2□No	
	vith th	Dire	10e. Street and Number				10f. Zi	Code			10	g. Citizen of	What Cou	ntry?	
	hours after deeth with the Maryland ture!, or Items 23e or 28e-f show at Examiner must be notified at	ral	7241 Joplin			1			2074			_		States	_
_	item item	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🏋		i. 13. V	vas Dece i Yes, spe	dent of Hi cify Cuba	ispanic Origir In, Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)		ce - Amen ick, White,	can Indian, etc.	
20	irs af	by F	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:	••	1	□ Yes	2 🔀 No	Specify:			Specia	fy: B	lack	
21215-0036	be filed within 72 hours after deeth with the Marylar die Hygiene.  de thy giene.  de other than "naturel", or liems 23a or 28a-f show only it is Madical Examiner must be notified at event, the Madical Examiner must be notified at	ted	15. Decedent's	Education	1	16a. Deced	lent's Usu	al Occupa	ation		1	6b. Kind of B	Business/In	dustry	
212	within 72 ene. then "na he Medic	ple	(Specify only highest   Elementary/Secondary (0-12)	completed) College (1-4or 5	;+)	(Give life. L	kind of wo	ork done d se retired	during most o I)	of working					
7	e filed withing Hygiene. other ther	Completed		4				Cle:	rk			P	rivat	te	
פ	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, La	st)					18. Mother's	s Name (Fir	st, Middle, M	aiden Sumai	me)		
<u>ya</u>		၉	Abrahar	n Ross							Effie	Reese			
Maryland	2 sh and ie m		19a. Informant's Name/Relationship				_				ute Number,	,			
	is 1 end 2 should of Health and Mer item 27 ie marke other traumatic		Gardenia P. Hil	11/Close Fr						-	ol Hei				_
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	Cei	ice of Dispoi metery, cren	natory or o	me or other plac	e)	Date	2	Oc. Location	- City or T	own, State	
	permit. Pages Depertment of I Important: If its any injury or o		4 Donation 5 Other (Spe		Linc				Cem. 7/			Atlan			_
g	Depe Depe Impo any ir		21. Signature of Funeral Service Lic	ensee	611	22			ss of Facility		wart F				
			23a Part 1 Ever the disease or or	Mustal	the leath	Do not ont					., NE		עט ג		_
			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Chrise (Final	ly one cause on each li	ne.	Do not ente	er the mod	ie or dyln	g, such as ca	ardiac or res	spiratory arres	st,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a		lure	to th	rive						Months	
	Examiner			Due to (or as		ence of):									
		-	Sequentially list conditions, if any, leading to immediate	b. Deme Due to (or as	ntia	ence of):							-		_
	uted I Insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			's Di	sease	<b>5</b>							
<u>,</u>	be executed sicien end burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as			Jease								
_	00 27 00	cal		d											
															_
X R O	death certifica e ettending ph ed for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1∐Live birth			lEctopic p	rednancy				23d. Da	ate of deliv	ery	
. H	0 0 2	sici	in the past 12 months?	4 Pregnant at 9 Unknown			Other (sp					M	onth	Day Year	
J.	that the de and by the e	Phy	9 Unknown									1			
ŝ	The law requires thet the te has been signed by th page 2 should be deteche		Part II. Other significant condition:	contributing to death b	ut not resul	ting in the ur	iderlying o	ause give	en in Part I.					he cause of death?	
Vital Records,	w requires to been signer should be	Completed								_	1   Yes	2 🗆 No	3 L Proi	oably 4 □Unknown	
ē	The law cete has t page 2 s	du								_	24a. Was an autopsy		prior to co	opsy findings available impletion of cause of	
	W L4	S		<del>-,</del>		_					perform 1 ☐ Yes 2]		death?	2 🗆 No	
	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	1001000		eck only one				
ō	Phys rthis raldi	<u>د</u>	1 ☐ Yes 2♠ No  27. Manner of Death	1 ☐ Inpatie		P/Outpatien 28b. Time of			4 TVIANI2		5 Residen			(y)	_
0	ding h After	tlon	1 Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	м	28c. Injun Work	γαι ⟨? Yes 2∐No		Describe nov	r injury occur	1180		
DIVISION	or Attending after death. Director; After in by the fune	flca	3 Suicide 6 Could no	be 200 Place of Init	urv - At hon	ne farm stre					ocation (Stre	et and Num	ber or Rus	al Route Number.	_
=	5 g g c	Certification:	4  Homicide determine	building, et	c. (Specify)		201, 140101	y, omoc			City or Town,		50. 0. 7.0.	ar riodio riombor,	
	Hospital     24 hours a     Funeral     intely filled		29a. Certifier 1 ☐ Certifying	Physicien: To the best	of my know	ledge, death	occurred	at the tim	ne, date and	place, and	due to the cau	use(s) and m	anner as s	stated.	_
	n 24 ho	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	i examinatio	on and/or inv	estigation	i, in my o	oinion, death	occurred a	t the time, dat	e and place,	and due t	o the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifier	/ 1	/		-	c. License			29	d. Date signe	ed (Month,	Day, Year)	_
^	10			May		Cm	ل	137	1261			July	6, 2	2007	
1	(2)		30. Name and address of person vi	o completed cause of d	eath (Item :	23а) (Туре,	Print)		, , ,						_
			Richard ).	Feldman, l				poli	s Rd.,	#A-4	, Lanh	am, MD	2070	)6	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	and)	,								
1	Registr	ar	JUL 1 1 2007	Alexand A	U. 19	No.									

DHMH 17 Rev 1/2001

, 125	,		1 - For State Registrar	State of M	arylan			nt of H te of L		and M	ental H	ygien Reg. N	21111	23	803
	Physici /Medic		1. Decedent's Name (First, Middle, Anna Ma								2. Date of D Month July		2007		of Death
44	Examir Funeral Director	er	4a. Facility Name (If not institution, Holy Cross Hos  5. Social Security Number 182-14-8731	pital		last birthday) Yrs.	S	ilver		Lng	8. Date of B (Month, E 09-27	irth Day, Yea.	c. County of Dea Montgome  9. Bir r) 4 Alto		_
Later	time, tible analysis of a coupling.	tor	Usual Residence of Decedent  10a. State 10b. County  MD Montgot	mery	10c. City	y, Town or Lo		ng			0) 21	1)2	7 711	10d. Inside	
	h with the 3a or 28a st be notif	Funeral Director	10e. Street and Number 3142 Gracefield	Road, #613			10f. Z	ip Code	20904			10g. C	Citizen of What Co	ountry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Mantal Status  1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 Tyes 2 1 If Yes, Give Year or Dates:	>	- 1	Was Dec If Yes, sp 1 □ Yes		spanic Ori n, Mexicai Specify:	igin? (Spe n, Puerto F	cify Yes or N Rican, etc.)	lo-	14. Race - Ame Black, Whit Specify: Tw		
21215-0036	I within 72 ho piene. r than "natur the Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	s Education grade completed)  College (1-4or	5+)	life. L	kind of w DO NOT	ual Occupa ork done c use retired aker	lurina mos	t of workin	ng	16b.	Kind of Business	•	
land 2	uld be filed Mental Hyg Irked other Itic event,	To Be C	17. Father's Name (First, Middle, L Otto Bohner	ast)						er's Name na Ma		e, Maide	en Surname)		
, Mary	and 2 sho ealth and 1 n 27 Is ma		19a. Informant's Name/Relationshi Thomas Pau1/Hus1			3142	Grac	efiel		ad, #	613,	Silv	er Sprin	g, MD	20904
altimore, Maryland	nit. Pages 1 artment of H ortant: If Iter Injury or ott		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.  21. Signature of Feneral Service D	ecify)	0		natorý oi leave	other plac	tery	07-10	ate 0-2007	Silv	Location - City or Ver Spri 39 Balti	ng, MD	701110
Ba	Depart Impo		23a. Pert1. Enter the disease, or or shock, or heart failure. List of	Marke 1	✓OIЧ d the deat	9) Ga	asch	s Fu	neral	Home		• Нуа	attsville	Approximal	20781
68760,	Physician /Medical Examiner be executed by sician and physician and street transit the prival-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any terms of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Responsequence a consequence a	uence of):								Onset and	1 Death
P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	∃Ectopic ∃Other (	pregnancy specify)					23d. Date of de Month	livery Day	Year
	The law requires that the death certite has been signed by the attending age 2 should be detached for use a	by	Part II. Other significant condition Hypotensi Sepsis	_	out not res	ulting in the ur	nderlying	cause give	en in Part I		10	] Yes	use contribute to	robably 4∑	Unknown
or Vital Records,	in: The lav ificate has or, page 2 s	<b>Completed</b>	25. Was case referred to medical						OC Disease		per	opsy formed? 2 <b>K</b> N	prior to death?	utopsy finding completion of 2 2 No	cause of
Division or Vi	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certification: To Be	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2  Accident investiga 3 Suicide 6 Could no determin	28a. Date of Inju (Month, Date)	ury ay Year) jury - At ho		f M	28c. Injun Work 1 🔲 '	er: 4□NL	ursing Hon 2 No	ne 5 Res	sidence how inj	6 □Other (Speciary occurred  and Number or Rate)		ımber,
_	e Hospital 24 hours a e Funeral letely filled	Medical Ce		Physician: To the best xaminer: On the basis of and manner st	of examina										:(s)
	To th within To th	Me	29b. Signature and title of certifier				2	D0055					July 6,		
2	(5)		30. Name and address of person w Delroy Anglin, M	D, Holy Cro	ss Ho	spital	L, 15	00 F	orest	Gler	n Road	, Si	lver Spi	ring, M	20910 D
	Sta Registi		31. Date filed (Month, Day, Year)	32. Regist	o.	fred !									

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Richardson 67 Lula 0 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner WICOMICO ENINSULA RECIONAL DALISBURY MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** 219-36-6812 1 M 2 XF 100 Maryland 8/12/1906 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show a or 28a-f show t be notified at 1 ☑ Yes 2 ☐ No Director Willards Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21874 7054 Bent Pine Road 23a 7 Is marked other than "natural", or items 23s traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No white Maryland 21215-0036 Specify: þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Int: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Education 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella White Brittingham Edward Elwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO Box 4600, Ocean City, MD 21842 E. Dean W. Richardson/son Department of Health Important; If item 27 any injury or other tronce. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/7/07 Pittsville, MD Pittsville Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the disease, or heart failure. List only one cause in each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Deert Failure DA **Physician** /Medical Due to (or as a consequence of) BURTTE Examiner 1 enons 10+413 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of high) that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician at the burial P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ N/Bas/H 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 X No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After 1 Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) 32. Regis

DRIVE
32. Registrar's Signature

muledo)

Day, rear)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of foods

HELEN M.

BALDADO MI)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** -05-2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salybury WICOMICO Coaslad Hospia the loke If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 🖫 F Hours Director 88 213-14-1100 1/19/1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Riverside Dr., Apt. C217 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No white þ Specify 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Sales retail clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry James Whayland Betty Mae Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Bowen/son 805 Parkhurst Dr., Salisbury, MD 21804 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Department Important: If any injury o Salisbury Crematory 7/6/07 Salisbury, MD <sup>22. Name and Address of Facility</sup> Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 snatur of Funera Service Livense 23a. Part. Enter the disease, or complications that complications, or heart failure. List only one cause each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as. signed by the attending I be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown After this certificate has been si funeral director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an was autopsy performed? 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

200

State Registrar 31. Date filed (Month, Day, Year) **JUL** 1 0 2007

GHULAM

COASTAL HOSPIC 32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Aprile

P.O BOX 1733 SALISBURY UD 21802

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 1:25 PM RONALD H. RIPPLE July /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BERLIN NURSING & REHABILITATION CTR. BERLIN WORCESTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Director APRIL 1, 1934 PENNŚYLVANIA 283-28-0512 73 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yos 2 No Director MARYLAND WORCESTER OCEAN CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13501 HOLLY LANE APT. C3 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Affiled Forces: 1 XYes 2 □ No If Yes, Give Year or Dates: 1954-56 1 Never Married 2 Married RIPPLE, RONALD H. altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR TRUCKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I RIPPLE JAMES WALTER ROSE PERROTT 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANA S. RIPPLE/WIFE 13501 HOLLY LANE, APT. C3, OCEAN CITY, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 7/9/07 4 □ Donation 5 □ Other (Specify) DELMAR, DELAWARE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (pr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Soknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 22 No death? 1 ☐ Yes 2 ☐ No 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) NO No Other: 1 🔲 Inpatient ပို 1 ☐ Yes 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No ours after death.
neral Director: A 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signal re a 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernet Ideal, De 11 Clados 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

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**Physician** /Medical Examiner Examiner The law requires that the death certificate be executed burial-tran and Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical

**Physician** 

/Medical

**Examiner** 

Funeral

Director

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25. Was case referred to medical examiner?

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Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pembrook Sa Suite 304 Waldorf, 1/350 gistrar's Signature Kau · nde R JUL 0 6

State Registrar

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State

Debra A. Vereen, 31. Date filed (Month, Day, Year)

M.D. 32. Registrar's Si

Registrar

Suitland, Maryland

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5001 Silver Hill Road; 2nd Floor

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#26perMD7/16/07, BW, Moco Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Rutledge 3:01AM\* Allen Carl 07/04/2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 928 Montgomery Street Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F 74 Yrs. 05/11/1933 Tennessee Director 459-48-3420 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, its Mardical Expiration must be notified at once. 1 ☐ Yes 2√ No Directo VA Northumberland Kilmarnock 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 22482 711 Guarding Point Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates 1950 – 1953 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 4 Inspector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carl Alley Irene Funk ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Katrine Court, Stafford, VA 22556 Deborah Nash/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Natl. Memorial Park |7/10/2007 Falls Church, Virginia `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7482 Lee Hwy. National Funeral Home, Falls Church, VA 22042 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** 917 /Medical Due to (or as a consequence of) Examiner UN G Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician by Physician/Medicai IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be LUNG 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes No No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Daughter's Home Other: Hospital: 1 ☐ Yes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home -5 Residence 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 2 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 29a. Certifier ta Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Rice Perry 10:55 Albert 2007 July 9, Α /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg Frostburg Village Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 10 / 19 / 19 18 5. Social Security Number **Funeral** 1 M 2 □ F Days 88 Yrs 214-07-3680 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b County or itema 23a or 28a-f ehow miner: sat be notified at 1 ☐ Yes 2 🛛 No Cumberland Allegany Director 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21502 10911 Kreigbaum Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status the Medical Examiners Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or ite ury or other traumatic event, the Medical Examina 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) Laborer Textile 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frankenberry Rice Charles Albert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10911 Kreigbaum Road, Cumberland, MD 21502 V. Maxene Rice / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. Restlawn Mem. Gardens 07/12/2007 LaVale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home. 21. Signature of Fugeral Service Licensee 404 Decatur Street, Cumberland, MD alle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stago ear **Physician** /Medical Due to (or as a consequence of): Examiner Diseas 2 er mer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant / in the past 12 months? 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time ot death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 VNo 1 [] Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Infury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9-200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Tarn Terrace, Frostburg, MD 21532 Sikander L. Sandhir, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 0 2007 Registrar

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	er dea	E	T. Marital Otaldo	2. Was Decedent I Armed Forces?		S. 13. 1	f Yes, spe	edent of H	ispanic Origin? ( in, Mexican, Pue	Specify Yes or Norto Rican, etc.)		ck, White,	
20	s afte	놀	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	10		1 ☐ Yes	2 🔼 No	Specify:		Specif	y: Whi	te
Ş	n 72 hours "natural", adical Ex	Completed by	15. Decedent's Educ			16a. Dece	dent's Usi	ual Occup	ation		16b. Kind of B		
5	in 72	ig	(Specify only highest grade	completed)		(Give	kind of w	ork done d use retired	during most of w	orking			
72	filed withi Hygiene. rther than ent, the M	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5	+)	Kent C	count	y Scl	nool Boa	ard	Educat	ion	
D	be filed ntel Hygi od other event, I	ပ္	17. Father's Name (First, Middle, Last)					_		ame (First, Middle	, Maiden Sumai	пө)	
a	should be filed withind Mentel Hygiene. merked other than imatic event, the M	To Be	William Smith						Elizabe	eth Dave	nport		
Maryland 21215-0020	d 2 should th and Men 7 Is marke trsumatic	-	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Addres	s (Street	and Number or I	Rural Route Numb	ber, City or Town	, State, Zip	Code)
	2 E E		Larry Evans/Guardia	ın		120 M	arvla	and A	ve.,Edg	ewater,	MD 2103	7	
ē,	s 1 and 2 f Health tem 27 I	-	20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Na	ame of		Date	20c. Location	- City or To	wn, State
9	Pages nent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 🛣 Donation 5 ☐ Other (Specify)	moval from State	Ană	ESITY 'C	GITTS	r Reg	istry	7/7/07	Glen Bu	rnie	Maryland
Baltimore,		-	21. Signature of Funeral Service License	0//					ss of Facility				
B	permit. Depertr Importa any inje		140			Н	ollo	way E	uneral	Home PA	Max	arl and	1 21 80 <i>/</i> l
		$\dashv$	27a Part 1 Enter the disease or complic	eations that caused	the death	Do not ent	oOT S	onow	HILL KO	. Salisb	ury, ran arrest	утапс	Approximate
	· · ·		23a. Part1 Enter the disease, or complic shook, or heart failure. List only one	cause on each lin	10.	\			<b>9</b> , ••••	,			Interval Between Onset and Death
an i	Physician / /Medical		Immediate Cause (Final	012	201	). / / /	0	_	10000	4			
	Examiner		disease or condition resulting in death) a.	CARDI	orc	LILL	na	uj	TIFFEE	1			
		ē		Pas	Due to (or	ras a consec	quence or	): ()	. 47 44	10.7	/	1	
	be executed sician and bunel-transit	튙	b.	DROWC	Due to	elle consec	UPDCe of	ECIN	oma	LIF1	DWER	V pe	
Ć.	exection and and training the	X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.		200101	40 4 00/1000	14000 0	,.				į	
8760,	cate be executed obysician and the bunel-transii	Completed by Physician/Medical Examiner	that initiated events		Due to (or	as a conseq	uence of	l:			*		
68	ificate g physi as the	8	resulting in death) Last										
Box	eath certifi ettending   I for use as	⋛│	d.										
œ.	death e ette	Cia	Part II. Other significant conditions cont	ributing to death be	ut not resu	ulting in the u	nderlying	cause giv	en in Part I.	23b. Dic	I tobacco use co	ontribute to	o the cause of death?
0	that the de ed by the e detached t	چا	•				, ,			1	Yes 2□ No	3 □ Pro	babiy 4 Unknown
σ.	es that igned I	٦	Hypenteusem							-			
of Vital Records,	v requires that the death certifice been signed by the ettending I should be detached for use as	평	Hypenteusem Left sided p	7	*						s an autopsy formed?	av	ere autopsy findings vailable prior to
ပ္စ	law rei as bee	Se	- Left sided f	nuuw	Wen					-		of	ompletion of cause death?
R	The law ate has b	E								10	Yes 240 No	10	□Yes 2□No
ta	icien: T certificat rector, p	Be C	25. Was case referred to medical						26. Place of D	eath (Check only	one)		
<u>&gt;</u>	Physicien: rthis certific	은	examiner? 1 ☐ Yes 2 ② No	ospital:	nt 2	ER/Outpatier	nt 3□ 0	OA Oth	er: 4 \( \text{Nursing}	Home 5□Res	sidence 6 □Ot	her (Specia	fy)
0	a Physerthi	[ ]	27. Manner of Death	28a. Date of Inju (Month, Da)	ry V Year)	28b. Time o	f	28c. Injur Wor	y at k?	28d. Describe	how injury occu	rred	
0	Attending F r death. sctor: After by the funer	읉	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day	7 (00.1)	ii ijui y	М		Yes 2□No				
Division	Atte	울	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injude	ury - At ho	me, farm, sti	reet, facto	ry, office		28f. Location City or To	(Street and Num own, State)	ber or Rur	al Route Number,
	s after	Se		Janan g, an	( - ) ,	,							
	Hospital 24 hours Funeral rely filled	edical Certification:	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examin	cian: To the best o	of my know examinat	wledge, deatl	h occurre vestigatio	d at the tir	ne, date and pla pinion, death oc	ce, and due to the	e cause(s) and m	anner as s , and due t	tated. o the cause(s)
			one)	and manner sta	ated.						29d. Date sign		
	To To con	Σ	29b. Signature and title of certifier	0 0	**		2		e number		,	-	
	80,	J	J. C. Cluck	of In	W.	1.		NZ	3889	7	7/9	107	P
	192		30. Name and address of person who cor	67.16	eath (Item	23a) (Type,			, ,			,	, Wel 216 20
			Volum C. ARRA		, t	1.0.	20	1314	igh St	reet, C	Her Kest	own,	, Wel 21620
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ars Signa	ture	,			,			
	11-21-51	1	A 2 2 3 2 1 1 2 / 1 3 1	1 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (		24 4							

DHMH 16 Rev 6/95

		1 - State Registrar			Cei	rtificate of	Death		Reg. No.	1	2001
, buois		1. Decedent's Name (First, Middle	, Last)					2. Date of I	eath Day	Year	3. Time of Death
hysici /Medi		Helen W. Saia				,		July	01	2007	
Examir	ner	4a. Facility Name (If not institution				4b. City, Town,	or Location of De	eath		ounty of Deat	
	ψ ,	Future Care- C 5. Social Security Number	hesapeake	7. Age (In yrs.	last histhday)	Arnol If Under 1 Yea		drs 9 Date of 6		ne Aru	
uneral irector		219-16-0177	1□ M 21 F	84	Yrs.	Months Days		in. (Month, I	Day, Year) 23, 19:	22 Ma	hplace (State or Fore nuntry) ryland
		Usual Residence of Decedent						Dec.	23, 13.	cz ru	
show det		10a. State 10b. County			ity, Town or Lo	ocation					10d. Inside City Lin 1 ☐ Yes 2X
8a-f	ecto	MD Anne A	runger	AI	mold	1			10 000		
23a or 2	ai Dir	1339 Baltimore	Annapolis	Boulev	ard	10f. Zip Code 2101			US US	in of What Co SA	ountry?
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examples must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	Armed Fo	2 <b>∑</b> No ve		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X No	ban, Mexican, Pu	(Specify Yes or fuerto Rican, etc.)		. Race - Ame Black, White pecify: W.	
ical E	Completed by	15. Decedent (Specify only highes			16a. Dece	dent's Usual Occu	upation	working	16b. Kind	of Business/	Industry
4	nple	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT use retir	ed)	working	-		Q
E ST	Con	12			Ra	iter					Company
e ven	Be	17. Father's Name (First, Middle, I						Name <i>(First, Midd</i> hea Fred	-	umame)	
nark	은	Joseph Wiseman			10h 14aiii	no Address /Con-		r Rural Route Num		Town State 3	Zin Code
27 Is r traur		Dorothy A. Thom		iter		-					Ld, MD, 2101
item (	- W	20a. Method of Disposition		20b.	Place of Dispo	osition (Name of		Date		tion - City or	
y or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		State G1	en Have	matory or other pl en Memor	ial 07	7/05/07	Glen	Burnie	e, MD
Importar sny inju once.		21. Signature of Euneral Service I			Ba	Park 2. Name and Add arranco &	& Sons,	P.A. Sev Hwy, Sev	erna P	ark Fu	neral Hom
sician edical miner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a C1			SELLA	R Dis	EASE			Interval Betweer Onset and Death
Ş.	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	(or as a consec	quence of):						
attending physicien and for use as the burial-transit	dical	that initiated events	c	(or as a consectors of pregnicity 2   Fetinant at time of	quence of): quence of): nancy al death 30	□Ectopic pregnan	ісу		23	d. Date of del Month	livery Day Year
igned by the attending physicien and be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 24 No 9 Unknown	c	(or as a consectome of pregnant at time of cown	quence of):  quence of):  ancy al death 30 death 50	Other (specify)			d tobacco use	Month  contribute to	Day Year
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Funeral Director: After this certificate has been signed by the attending physicien and ely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C	tcome of pregnointh 2 Fethant at time of cown leath but not resident the property of Injury th, Day Year) e best of my kn	quence of):  quenc	other (specify)  Int 3 DOA Control 28c. In Windows Interest, factory, office the occurred at the prestigation, in more	26. Place of Other: 4 Mursin ury at ork?  Yes 2 No	24a. We au per 1 yes Death (Check only ng Home 5 Re 28d. Describe 28d. Location City or 1	d tobacco use  Yes  as an topsy rformed?  2 No y one)  Isidence 6 e how injury rown, State)	Month  a contribute to  No 3 Pr  24b. Were au prior to death? 1 Yes  Other (Special Control of the Control of t	Day Year  to the cause of death'  robably 4  Unknot  utopsy findings availate  completion of cause  2  No  crify)  ural Route Number,
Funeral Director: After this certificate has been signed by the attending physicien and ely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C	tcome of pregnointh 2 Fethant at time of cown leath but not resident the property of Injury th, Day Year) e best of my kn	quence of):  quenc	other (specify)  Int 3 DOA Control 28c. In Windows Interest, factory, office the occurred at the prestigation, in more	26. Place of Other: 4 Mursin ury at ork?  Yes 2 No	24a. We au per 1 yes Death (Check only ng Home 5 Re 28d. Describe 28d. Location City or 1	d tobacco use  Yes  as an topsy rformed?  2 No y one)  Isidence 6 e how injury rown, State)	Month  a contribute to  No 3 Pr  24b. Were au prior to death? 1 Yes  Other (Special Control of the Control of t	Day Year  to the cause of death'  robably 4  Unknot  utopsy findings availate  completion of cause  2  No  crify)  ural Route Number,
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DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar			mar y tar	-	tificate of	Death		Reg. No.	07	23820
	Physici	an	1. Decedent's Name							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Philip Bu					41- O't- T	- 1 1 1 1 1		/2007	- ( D - 1)	9:05an₩
	Examir	er	4a. Facility Name (If I		, give street and num Veterans				or Location of Deat		4c. County	of Death Mary	.te
	Funeral		5. Social Security Nu		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	_If Under 24 Hrs.	8. Date of Birtl	h ,	9. Birthp	lace (State or Foreign
	Director		579-46-15		1 X M 2 □ F	71	Yrs.	Months Days	Hours Min.	3/7/I	936	Washi	ngton, DC
	and w		Usual Residence of I 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Maryl -f sho	tor	MD	Anne A	rundel		Edgewa	ter					1 □Yes XXNo
	th the or 28a e noti	Director	10e. Street and Num	ber				10f. Zip Code			10g. Citizen of	What Cour	try?
	ath wi		468 River	view D				210			US		
	items	Funeral	11. Marital Status 1 □ Never Marrie	d 2 Marri	12. Was Deced	ces?	.S. 13.	Was Decedent of I f Yes, specity Cub	Hispanic Origin? (S oan, Mexican, Puer	pecity Yes or No- to Rican, etc.)	14. Rad Bla	ce - Americ ck, White,	
36	urs aff		3 ☑ Widowed 4		If Yes, Give Year or Da	<sup>2□No</sup> 196 tes: 196		I□Yes 2█ No	Specify:		Specif	y: Wh	ite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	(Specif	15. Decedent	's Education at grade completed)	3.7	16a. Dece	lent's Usual Occu	pation	rking	16b. Kind of B	usiness/Ind	lustry
121	within iene. than "	mple	Elementary/Secon		College (1-	4or 5+)	Sal		during most of wor ed)	All 19	Ion	itar	Supplies
d 2	a filed value of Hygie	CO	17. Father's Name (F	-irst. Middle.	Last)		Ja1		18. Mother's Nar	ne (First, Middle,			Supplies
lan	should be nd Mental marked o	To Be	Morris Se		,					e Purzit		,,,,	
ary	2 should and Men Is marke		19a, Informant's Nar	ne/Relationsh	nip (Type. Print)		19b. Mailir	g Address (Street	t and Number or Ru			, State, Zip	Code)
Σ,	D € 12 =		Mindi Sei		ler Dau	ghter		st Squar	e Drive	Richmon			
ore	ges 1 it of H If iter or oth		20a. Method of Dispo		3 ☐Removal from S	tate (	emetery, crei	sition (Name of natory or other pla		Date / O O O O	20c. Location	•	wn, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 3 any Injury or other once.		4 ☐ Donation :			Mt.			ery 7/10	I	Adelphi	-	
Ba	Depa Impo any Ir once		1-13-	J.C	J		12	Ridgely	ess of Facility Har Ave. Ani	rdesty Fi napolis,	uneral MD 214	Home, 01	P.A.
	120		23a. Part1. Enter the shock, or heart	e disease, or	complications that ca	used the deat ch line.	h. Do not ent	er the mode of dyi	ing, such as cardia	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (F	inal	P	ARK	INSC	N'S	Dis	SEAS	$\epsilon$		Onset and Death
	/Medical Examiner		resulting in death)		Due to (d	r as a conseq	uence of):		eumo				l
	\$ N	e	Sequentially flet con- if any, leading to imm	ditione, nediate	b. Due to (c	Spir or as a conseq	uence of):	7 1 11	La WIO	VIII			
	cuted nd ransit	Examiner	if any, leading to importance. Enter Underl Cause (Disease or in that initiated events	ying ijury	a T	usr	oha	a ia					
30,	oe exe cian al nurial-t	EX	resulting in death) La	ıst	Due to (d	r as a conson	uence of): .		Co	1 , 1100	· 0 · 1 ·	,	sease
68760,	certificate be executed rding physician and ise as the burial-transit	Physician/Medical			d. #1	ren	ろこに	20110	- avc	المالاه	scula	r Cu	sease
Box (	oel se	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outo			1-			23d. Da	ate of delive	ery
-	the death y the atter ched for u	sicia	in the past 12 n 1 ☐ Yes 2 ☐	nonths?		rth 2 ∐ Feta ant at time of d		]Ectopic pregnand ] Other <i>(specify)</i> _	СУ		Me	onth	Day Year
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ital		Be C	25. Was case referre	ed to medical				<del></del>	26. Place of Dea	1 Yes ath (Check only o		1 🗌 Yes	2   No
Division or Vital	G 5. ≺	10 E	examiner? 1 ☐ Yes 2 2 1	10	Hospital: 1 ☐ Ir	patient 2 🗆	ER/Outpatier	t 3□ DOA Oti	her: ANursing H	lome 5□Resid	lence 6 🗆 Oth	ner <i>(Specif</i> )	)
o uc	ing P	ii o	27. Manner of Death Natural	5 Pending	•	f Injury n, <i>Day Year)</i>	28b. Time o Injury	Wo		28d. Describe h	low injury occur	red	
isic	Attending r death. ector: After by the fune	ficat	2 ☐ Accident 3 ☐ Suicide	investig	ot bo	of injury - At ho	 ome, farm, str		]Yes 2□No	28f. Location /S	Street and Numl	ber or Bura	I Route Number,
Ö	al or / s after il Dire	Certification:	4 Homicide	determi	buildin	g, etc. (Specif	y) .	eet, factory, office		City or Tow	ın, State)		
	e Hospital 124 hours a e Funeral I letely filled		29a. Certifier (Check only	Certifying	g Physician: To the l Examiner: On the ba	pest of my kno sis of examina	wledge, deat	occurred at the tweetigation. In my	ime, date and place	and due to the curred at the time.	cause(s) and m	anner as st	ated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Medical	one) 29b. Signature and t		and mann	er stated.		29c. Licens			29d. Date signe		
	(0)		· OB	111	Ala	W	1		15092	_   '	7/2	10	7
	(10)		30. Name and addre	ss of person v	who completed cause	of death (Iten	1.23a) (Type,		·		<u>・し</u> フ	10	1
	CH		110 Has	pita	1 Poag	Su	ite	205	Prince	treo	lvick	N	D 20678
15	Sta Registr		31. Date filed (Month	i, Day, Year)	0 5 2007 Re	gistur's Signa	ture	A. s				,	

			1 = For State Registrar	State of M	aryland / De <i>C</i>		of Health a			ene g. No.	7	382	
	Dhusisis		1. Decedent's Name (First, Middle,						Date of Death Month	Day Y	'ear	. Time of Death	1
	Physicia /Medic		FRANCES	MARIE	STEWART				JULY	3 200		6:45A	М
	Examin	er	4a. Facility Name (If not institution, WASHINGTON A				wn, or Location of KOMA PAI			4c. County of		v	
					ge (In yrs. last birthd			24 Hrs. 8	Date of Birth		GOMER Birthplace		eian
de.	Funeral Director		5. Social Security Number 579-52-1679		70 Yrs	Months [	Days Hours	Min. M	(Month, Day, AY 29	Year) 1937 M	Country)	State or Fore	3
			Usual Residence of Decedent										
	how how	. [	10a. State 10b. County		10c. City, Town or	Location						Inside City Lim	
	B Marian	ctor	MD PRINCE	GEORGE'S	GREE	NBELT						1∰Yes 2□	
	or 28	Director	10e. Street and Number			10f. Zip C	ode		10	g. Citizen of Wh	at Country	?	
	ath w	ra	6156 SPRINGHILL	TERRACE #	203	20	770	ining /Const	Vac or No	U.S.	American	Indian	
	er de Items	nue	11. Marital Status  1 □ Never Married 2 □ Marrie	12. Was Decedent	?	If Yes, specify	nt of Hispanic Or Cuban, Mexica	n, Puerto Ric	an, etc.)	Black,	White, etc.		
36	II', or	by Funeral	3 Widowed 4 Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give 4 Year or Dates:	K."	1 Yes 20	XNo Specify:	:		Specify:	BLAC	K	
ŏ	72 hours after death with the Maryland Instural; or Items 23s or 28s-f show dical Examinat must be notified at	Completed	15. Decedent's	Education	16a. De	cedent's Usual (	Occupation done during mos	et of working	1	6b. Kind of Bus	ness/Indus	try	
215	within 7 ene. than "n	ed l	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+) lif	a. DO NOT use	retired)	a or woming					
21	filed with Hygiene. other than	Con	10th	1	HC	ME MAKE		-d- N //	ima Adiddle A	PRIVA faiden Sumame			
pu	be fill tal H od ott	Be	17. Father's Name (First, Middle, L JOSEPH STEWART	ast)				GARET	JONES	iaiden Sumame,	,		
yla	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, tham	٦°	19a. Informant's Name/Relationshi	n (Time Print)	10h M	ailing Address /				City or Town, S	tate Zin Co	ode)	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho It of Health and Mental Hygiene. If item 27 is marked other than "nature or other traumatic event, Ital Mazilcal	ĺ	TONY STEWART/S							REENBELT			)770
	permit. Pages 1 and 2 Department of Health s Important: If item 27 li eny injury or other tra		20a. Method of Disposition		20b. Place of Di	sposition (Name	of	Date	9 2	20c. Location - C	ity or Town	, State	
20	Pages nent of h ant: If ite		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		HARMONY	rematory or other	l l	7/9/2	007	LANDOVE	R.MAR	YLAND	
Baltimore,	artme ortan injur		21. Signature of Funeral Service L		Initiatoria		Address of Facil			KINS FU	-		
Ba	Depa Impo eny i			2		7474 L	ANDOVER	ROAD	LANDOVE	ER, MARYL	AND	20785	
	> 16 g		23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that cause	ed the death. Do not	enter the mode	of dying, such as	s cardiac or r	espiratory arre	st,	In	proximate terval Between	
	Physician		Immediate Cause (Final disease or condition								0	nset and Death	1
	/Medical		resulting in death)		onitis s a consequence of):								
el.	Examiner		Sequentially list conditions	b	rticulitis								
	ש ש	Iner	Sequentially list conditions, in any, leading to infriediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a nunsaquenno of)								
	es that the death certificate be executed igned by the attending physicien and be detached for use as the buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	s a consequence of):								
760,	be ex cien cien	cal E	<b>3</b>	200 10 (0) 2	s a consequence on.								
687	physicate sthe			d									
×	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						23d. Date	of delivery		
Вох	leath atter 1 for u	clar	in the past 12 months?		2 Fetal death at time of death	3 ☐ Ectopic prec 5 ☐ Other (spec				Mont	h Da	ay Year	
0	the c by the ached	hysl	9 Unknown	9□ Unknown									
Δ,	s that th med by e detach	by P	Part II. Other significant condition	ns contributing to death	but not resulting in th	e underlying cau	ise given in Part	l.		acco use contrit			
ğ	w require been sig should b	ed							1 ☐ Ye	s 24 No	3 Probab	ly 4 ∐Unkn	own
Records,	awre as be	Completed							24a. Was a	y pr	ior to comp	findings avail letion of cause	able
Ä		E O							perform	ned? de	eath?	XNo	
Vital	Physicien: The law this certificate has t ral director, page 2 s	Be (	25. Was case referred to medical examiner?				1	e of Death (	Check only on	θ)			
of	Physic this o	2	1 ☐ Yes 2 ☒No		tient 2 ER/Outp					nce 6 Othe			
n C	ing wher	on	27. Manner of Death 1    Natural 5   Pending		jury 28b. Tim Jay Year) 28b. Tim Inju	ry M	c. Injury at Work? 1 Tyes 2 D		u. Describe no	w injury occurre	u		
isio	Attending r death. ector: After y the fune	cat	2 Accident investig 3 Suicide 6 Could n	ot be	niury - At home farm			28	f. Location (St	reet and Numbe	r or Rural F	Route Number,	
Division	or Attendi efter death Director: A	ertif	4  Homicide determi	building,	njury - At home, farm etc. <i>(Specify)</i>	, otreot, tactory,	omoo		City or Town	, State)			
_	ospitel or hours efte unerel Dir ly filled in	alc	29a. Certifier 1 Certifying	Physicien: To the bes	st of my knowledge, o	eath occurred at	t the time, date a	and place, an	d due to the ca	use(s) and mar	ner as state	ed.	
	To the Hospitel or Attent within 24 hours effer death To the Funerel Director: completely filled in by the	Medical Certification:	(Check only 2 Medical E	xeminer: On the basis and manner	of examination and/ostated.	r investigation, i	n my opinion, de	ath occurred	at the time, d	ate and place, a	nd due to th	ne cause(s)	
	To the within To the Comp	Σ	29b. Signature and title of certifier	$\sim$		29c.	License number		_1 2	9d. Date signed	(Month, Da	y, Year)	
			) Sand	a. U)	ie		23		1	1-4	-0	/	
R	(7)		30. Name and address of person	who completed cause of	2		AID ABO		EM DAE	1 . / 1	-MA	0 -	7770
	U		Sta 309 #	7521	7	vay C	Th_ D	112.	yru	nsell	رير.	201	100
1	Sta Regist		31. Date filed (Month, Day, Year)  JUL 1 0 2007		stral's Signature	w'							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 4-25 AM Madie Alta Smith 2.00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAR FORT VITIZENS NURSING Homs LAVRE. Ð GRACE If Under 1 8. Date of Birth (Month, Day, You Aug. 25, Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Days Year. Min Months Hours 1 □ M 2 🕅 F Director 88 Virginia 224-28-3826 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show be notified at 1 ☐ Yes 2x No Director Maryland Cecil Port Deposit 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 21904 20 York Drive U.S.A items 23a must death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**X** No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2X No. þ Specify: White 3 Widowed 4 □ Divorced "natural", Year or Dates Completed marked other than "naturatic event, the Months 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence Eleven Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be J.C. Cook Mary Ann Perkins other traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 473 Camp Meeting Ground Road, Port Deposit, MD 21904 George H. Smith 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or c cemetery, crematory or other p Clinch Valley 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 07/13/07 Richlands, Virginia Memorial\_Cemetery 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licens Dr. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical r as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immisurate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed the burial-trar and Due to (or as a Box 68760 sate has been signed by the attending physician page 2 should be detached for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 K No O. 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division or Vital Records, 1 ☐ Yes 2 🗆 No 3 ☐ Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 100 Yes 2 I No 1 TYes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No 1 □ Y9 P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Map er of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attency within 24 hours after death To the Funeral Director: 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕊 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 30. Name

31. Date filed

Year

MADI

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

		-	For State Registrar	St	tate of M	aryland	-	artment			ind M	lental Hygi	ene.		20023	
1.5%	E 5.		1. Decedent's Name (First, Mic	dle, Last)		·						2. Date of Death Month	Day	Year	3. Time of Death	
1	Physicia /Medic	_	NORMA	MAY		STOKES	3					JULY 8,	T		7:25 A M	
)	Examin	-	4a. Facility Name (If not institut	ion, give stree	t and number	r)		4b. City,	Town, or	Location o	f Death			ty of Death	1	
1868	- *		LAURELWOOD NU						ELK		24/1			CIL		
	Funeral	i	5. Social Security Number	6. Sex 1 ☐ M		lge (In yrs. las	t birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day,	Year)	Cor	aplace (State or Foreign untry)	
₩.	Director	-	222 16 2362 Usual Residence of Decedent			76						OCT 18,1	1930	MAN	RYLAND	
	land	1	10a. State 10b. Cour	ity		10c. City, 7	Town or Lo	ocation							10d. Inside City Limits	
	72 hours after death with the Maryland "netural", or Itema 23a or 28a-f ahow ulical Examiner must be motified at	to	MD CECIL ELKTON									XX Yes 2□				
		irec	10e. Street and Number 10f. Zip Code								10	g. Citizen of	What Col	untry?		
		a D	151 SECOND STREET 219							5			USA			
		To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I							gin? (Sp	ecify Yes or No- Rican, etc.)	ace - Amerack, White	ncan Indian, n, etc.			
9	or It		1 Never Married 2 X M	arried	Yes 2√ Yes, Give		1	1 ☐ Yes 2	-				Spec	ity:	WHITE	
21215-0036	ural',		3 Widowed 4 Divorced Year or Dates:								16b. Kind of					
5			(Specify only hig	ent's Education hest grade con			(Give	kind of wor DO NOT us	rk done a	during most	t of work		IOD. KING OF	Dusinessy	ndustry	
12	within 72 ene. than "na		Elementary/Secondary (0-12	(1)	College (1-4o	r 5+)		KKEEP		,			AUTO R	EPATR		
9	be filed tal Hygi d other event.		17. Father's Name (First, Midd	le, Last)		<u> </u>	DOO	KKEEL!		18. Mothe	r's Nam	e (First, Middle, M				
an			CARROLL MULL	IKIN						LI	DIE	CLARK				
Maryland	shound h		19a. Informant's Name/Relation	nship (Type,	Print)		19b. Maili	ng Address	(Street a	and Numbe	or Rur	al Route Number,	City or Tow	n, State, Z	ip Code)	
	Health a tam 27 la		ROBERT J. STOK	ES			151	SECON	D ST	REET,	CHI	ESAPEAKE	CITY,	MD 2	1915	
ore,	of Healt of Healt litem 2 r other		20a. Method of Disposition 1 □ Burial ※XXCremation	.a. 3 □ Dome	wal from Stat	20b. Plac	e of Disponent	osition (Name matery of o REMAT	ne of ther plac	e)			20c. Location			
Ĕ	Pages ment of P ant: If its ury or o		4 □Donation 5 □ Other	(Specify)	Jvai IIOIII Stat	FAMI	SERV	ICES	TON	J	ULY	10, 2007	MI	LMING	TON, DE	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Servi	ce Licensee	~	P	M	2. Name an EALEY	FUN	ss of Facilit ERAL	HOME	ES, PO BO	X 286	6, WI	LMINGTON 19805	
· *			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Onset and Death													
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*10.00	/Medical		resulting in death)  Due to (or as a consequence of):													
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		Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Undertying Cause (Disease or injury													
	and and II-tran		that initiated events c													
760,	ite be executed ysician and ne burial-transit	cai E														
687	2 2 2			d												
Box (	ath cer ttendir or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant									23d. [	23d. Date of delivery			
ğ		ciai	in the past 12 months?		4 Pregnant	2 □ Fetal d at time of dea		□Ectopic pr □ Other (sp					ì	Month	Day Year	
0	that the de led by the a detached f	hys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									1				
ر. ص	The law requires that the ste has been signed by th page 2 should be detache	by P								l.	23e. Did tol	acco use co	contribute to the cause of death?			
rd												1 🗆 Ye	es 2 No	3 🗆 Pr	obably 4 Unknown	
Records,	law re as be 2 sho	Completed										24a. Was a autops		prior to	topsy findings available completion of cause of	
Ä		mo;										perform 1 ☐ Yes	ned? 2 Ø No	death? 1 ☐ Yes		
Vital	ysician: Th is certificate director, pag	Be (	25. Was case referred to med examiner?								e of Dea	th (Check only on	e)			
of V	ding Phys n. After this funeral din	၉	1 ☐ Yes 2 ☐ No	Hosp	1 L tnpa		VOutpatie			4 NI	ursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)				
		on:									Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Sio		Certification:	2 Accident investig for M 1 Yes 2 No 3 Suicide 6 Could not be 38e Place of folium - At home farm street factory office													
Division	i Digita	ertif	3 Suicide 4 Homicide  Suicide													
_	spital ours neral filled		29a Cartifler 12 Carti ling Physician. To the pest of my knowledge death organization me gate and blace, and due to the causetst and manner as stated.									stated.				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	(Check only one)  2 Medi   Exa ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and displace, and displace and title of pertition  29b. Signature and title of pertition  29c. License number  29d. Date signed (Mon Day, Print)  30. Name and address of the son who completed cause of death (Item 23a) (Type, Print)  Aprend Store   B 7 CHNRHMON CTR NEW CASTE DE 1972C								e, and due	to the cause(s)				
	To th Withir To th comp	Me	29b. Signature and title of ce	titier				29	29c. License number 29d. Date sign				ned (Mont	d (Month, Day, Year)		
			) /HI	en				=   1	724	10/	>		09.	JUL	U +	
-			30. Name and addess of se	son who comp	leted cause of	of death (Item 2	3a) (Type	, Print)		۸ )-	1.0	- 1	107	7 -2		
	10		ARLEN STORE	~	817	CHURCH	mous	C71	2	UEN	J 645'	ノビ リモ	17/	20		
		ate	31. Date filed (Month, Day, Yo	1 1 200	32. R	istrar's Signatu	re K	boarde								
36	Regist	rar	JUL	CUL	TE C	MILLOW J		1	-							

3. Time of Death

Reg. No.

2. Date of Death

Dir

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Phys /Me Exar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Euneral Director After this conflicate has been sinned by the attending physician and

Division or Vital Records, P.O. Box 68760,

4a. Fally Stame (if not installation, give a preset and number)  Union Mospital  5. Social Security Name (if not installation)  5. Social Security Name (if not installation)  5. Social Security Name (if not installation)  5. Social Security Name (if not installation)  5. Social Security Name (if not installation)  100. City Town or Location (if not installation)  101. City Town or Location (if not installation)  102. City Town or Location (if not installation)  103. City Town or Location (if not installation)  104. City Town or Location (if not installation)  105. City Town or Location (if not installation)  106. City Town or Location (if not installation)  107. City Town or Location (if not installation)  108. City Town or Location (if not installation)  109. City Town or Location (if not installation)  109. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City Town or Location (if not installation)  100. City City City as or Installation (if not installation)  100. City City City City City City City City	n il	Patrici	a Marie	Sotirell	is				Ju1	7 10	2007	23:071		
Second Security Names   6 Sec   1 Case of pilm   1 Case		4a. Facility Name	(If not institution	n, give street and nur	nber)		4b. City, Town,	or Location of Deat			County of Death			
182-30-9674   11   Marie Resource of Decorate   10c. Country   10c. Chy, Town or Location   10c. State   10c. Country   10c. Chy, Town or Location   10c. Treated Chy   10c. Chy, Town or Location   10c. Treated Chy   10c. Chy, Town or Location   10c. Chy   10c. Chy, Town or Location   10c. Treated Chy   10c. Chy   10				1										
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Specify   Spec	<u>z</u>	555 Ce	cilton	Warwick R	d.		21913	3						
Specify   Spec	ב ב			Armed Fo	rces?	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or Note to Rican, etc.)	r No- 14. Race - American Indian, Black, White, etc.				
Joseph Howel1    Joseph Howel1				If Yes Giv	/e		1 ☐ Yes 2 ☑ No	Specify:		Specify: White				
Joseph Howel1  19b. Malling Address (Street and Number or Rural Route Number. City or Town. State. Zip Code) Christine Lucas/Daughter  20a. Memod of Disposition 1   Bund 2 2 Commation 3   Removal from State 4   Donation 5   Other (Specify) 21: Signature of Towner Services Licensee 22. Name and Address of Facility 130 Speer Rd. Chestert, MD  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and passes or respiratory arrest, inch	3		ecify only highe	t's Education st grade completed)		16a. Dece	edent's Usual Occu e kind of work done DO NOT use retire	upation e during most of wo ed)	orking	16b. Ki	ind of Business/Ir	ndustry		
Joseph Howel1    Joseph Howel1	Ę .	Elementary/Sec. 12	condary (0-12)	College (1	-4or 5+)					Но	memaker			
Joseph Howell   19a. Informant's Name (Relationship (Type Pint)   19b. Mailing Address (Street and Number or Naural Route Number. City or Town, State, Zip Code)	ນ	17. Father's Nam	e (First, Middle,	Last)				1	•		,			
Christine Lucas/Daughter  20a. Method of Disposition   Blurial 2 El Corenation   Sile	5					<u></u>								
20a. Method of Disposition						l l	•							
Chesapeake Cremation Ctr 7/12/2007 Chester, MD  21. Signature of Funeral Service Licensee  22. Name and Address of Facility I 30 Speer Rd. Chestertown, MD  Fellows, Helfenbein & Newnam Funeral Home, P.  23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Betwee Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)  23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Microral Betwee Cheet and Liv	-													
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Conset and Dead Interest Cause Final disease or condition resulting in death)  Beguentially list conditions, and the conditions cause. Enter Underlying resulting in death   Due to (or as a consequence of):  Due	23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approx										Approximate			
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24a. Was an autopsy findings avaprior to completion of cause death?  25. Was case referred to medical examiner?  1   Yes   2   No     No   Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Teath   Natural   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   28a. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number or Building, etc. (Specify)    28a. Certifier (Check only only only only only only only only	=					t reculting in the	undaduina aquaa a	iven in Dest I	220 Did	23e. Did tobacco use contribute to the cause of death?				
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25. Was case referred to medical examiner?  1	5		<u> </u>											
28a. Date of Injury (Month, Day Year)  28b. Timps of Injury of Injury Month, Day Year)  28c. Injury at Work? 1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurr	D	25. Was case referred to medical examiner? 26. Place of Death (Check only orle)												
Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number or Burlal Route Number or Rural Rou	- 1	/	7	1 1 1			SIL SU DOA	4 Nursing Home 5 Residence 6 Other (Specify)						
29a. Certifier (Check only one)  29a. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	5	1 Natural	5 ☐ Pendir	ng (Mon					28d. Describe	now injui	ry occurred			
29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	<u>g</u>		6 ☐ Could	not be	of injury	At home farm of			28f Location	(Stroot 2	nd Number or P.	ral Route Number		
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≥ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
20 Name and address of person who completed cause of death (Item 23a) (Type, Print) = 200 c = 5/11/200 7	Š	29b. Signature a	nd title of certific				29c. Licer			29d. Da	ite signed (Month	, Day, Year)		
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)			Door	Rou	D		D00060756. 7/11/2009							
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		1 - State Registrar AMEND#10a, b, cperFH7/10/07, BMW, Moco C		Reg. No.	7 2 225
Physic	cian	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year	3. Time of Death
/Med Exam		Florence Victoria Schaffner  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	11y 6, 2007 4c. County of De	11:05a <sup>™</sup>
Exam	niei	Holy Cross Hospital	Silver Spring	Montgome	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	ay) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth 9. B	irthplace (State or Foreign Country)
Directo	r	Usual Residence of Decedent		b. 23, 1914 Oh	* *
yland sow at		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
e Mar a-f sh tified	cto	Maryland Montgomery Burtons	ville		1 □Yes 2 No
vith th	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?
eath v	Funeral	P.O. Box 266, 15001 Old Columbia Pil		United Sta	ntes nerican Indian,
Safter d		Armed Forces?  1 □ Never Married 2 □ Married   1 □ Yes 2 □ NoWWII   1 Yes (Sive	<ol> <li>Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric 1 Yes 2 No Specify:</li> </ol>	an, etc.) Black, Wr Specify: Wh	nite, etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed by	XXVIdowed 4 Univorced Year or Dates:		Specify: W	
15-(	lete	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired)	16b. Kind of Busines	s/Industry
212 I withingliene.	omp		al Worker	Federal Go	vernment
0 m 0 %	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maiden Surname)	
arylance should be f and Mental F s marked of numatic eve	2	Simon Bartczak	Victoria S		
Mar d 2 sh th and 7 ls m traum	9		82 Marlhoro Court III	<u>-</u>	
the lead		20a Method of Disposition 20h Place of Di	82 Marlboro Court, Wo	200 Lengting Oite	or Town State
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any Injury or othe		X Burial 2 Removal from State Cedar H 4 □ Donation , 5 □ Other (Specify)	remetery Unk. ncoln Crematory 7-13-	Suitland, 1	-
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m garas		Censum Dosh I rowy	Pike	e, Rockville, MD	
	9	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		espiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  Failure to Thriv  a.  Due to (or as a consequence of):	e		
Examine		Alzheimer's Dis	ease		
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ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
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68/ tificate g phy as the	ledic	a			
Box 6 leath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death	3 □Ectopic pregnancy	23d. Date of d	
• 0 60	ysici		5 Other (specify)	Month	Day Year
that the ded by		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
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ecord law requir as been si 2 should I	Completed			24a. Was an 24b. Were a	autopsy findings available completion of cause of
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Or VITAI F Physician: The r this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (C	heck only one)	
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VISION ( Attending I r death. ector: After by the funer	ation	1 Natural 5 □ Pending (Month, Day Year) Injur 2 □ Accident investigation		. Boothoo how many occurred	
DIVISION tal or Attending s after death. al Director: Afte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office 28f.	Location (Street and Number or I City or Town, State)	Rural Route Number,
pital or urs afte		Vo divis Physics The hard			
To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 ★Certifying Physician: To the best of my knowledge, do 2 ★ Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, and rinvestigation, in my opinion, death occurred	at the time, date and place, and d	as stated. ue to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mod	nth, Day, Year)
1-VA		DYD/W	D0064100	July 6, 200	07
(10)		30. Name and address of person who completed cause of death (Item 23a) (Tyr	•		
s	ate	Smitha Bhikraji, M.D., 1500 Forest G  31. Date filed (Month, Day, Year)  32 pegistrar's Signature		ing, MD, 20910	
Regis		JUL 1 0 2007 Brown & A	poole	\$7	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4:57 AM Yenta Shvartsman 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 9. Birthplace (Stete or Foreign Country) 4 Ukraine If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, January 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yeer) Days Hours 1 □ M 2 F 1924 216-41-1327 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State in than "naturel", or Items 23s or 28s-f show the Modical Examiner must be notified at Rockville MD Montgomery X Yes 2 No Direct 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 6121 Montrose Road 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White etc. 1 Never Married 2 Marned 1 ☐ Yes 2 ☐ No If Yes, GiveX White 1 ☐ Yes 2 ☐ No Specify: À Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Legal Lawyer 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event size, but it is any in the content of the content in the 17. Father's Name (First, Middle, Last) Be Sheava "Unknown" Isaac Shvartsman P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3607 Pear Tree Court #14 Silver Spring MD 20906 Peter Shvarts - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/9/07 Chessed Shel Emmes Capitol Heights, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licepset Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physicien Physician/Medical IF FEMALE Sa M 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à RENAL INSUFFICIENCY 1 ☐ Yes 2 No 3 Probably 1A, SEIZURES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy LUNG CA 2 DENO this certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, n Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 25 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Injury 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel within 24 hours a To the Funeral E pélli rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person

completed cause of death (Item 23a) (Type, Print)

KORTAN 80 |
32 | sistrar's Signature

801 EAST DEFFERSON

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

DHMH 17 Rev 1/2001

Donald Lee Studevent    Comparison   Compari				1 - For State of Maryland / Dep	artment of Health and Martificate of Death		ene () () 7	23823
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Physician Medical Examiner    Part				23a, Part1. Enter the disease, or complications that caused the death. Do not en				Approximate
Compared to the control of the con		Physician		Immediate Cause (Final	Sixmeris			Onget and Death
Sequentially list conditions of any examination of the conditions contributing of the conditions contributing of the conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions of a consequence of conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions of a consequence of conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequentially list conditions contributions contributions contributions cause given in Part I.    Sequentially list conditions contributions cause given in Part I.    Sequentially list condit				resulting in death)	(10) 000			7 01110
August Enter Undersynan and State (Specify)    State		Cxammer	_	Sequentially list conditions, b.				
Section   Sect		led Isif	nine	cause. Enter Underlying				
Section   Sect		execu n and al-trai	xar	that initiated events c.				
FFEMALE:   23d. Date of delivery   23d. Date of Date	760	e be (						
State  1   1   1   1   1   1   1   1   1   1	89	tifical ng phy as th	= 1					
State  1   1   1   1   1   1   1   1   1   1	ŏ	th cer tendir r use	an/\	23b. Was decedent pregnant 23c. It yes, outcome of pregnancy	□Ectopic pregnancy			
1   Yes 2   No 3   Probably 4   Darkon   24a. Was an autopsy prior to completion of cause death? 1   Yes 2   No 3   Probably 4   Darkon   24a. Was an autopsy prior to completion of cause death? 1   Yes 2   No 3   Probably 4   Darkon   24a. Was an autopsy prior to completion of cause death? 1   Yes 2   No 3   Probably 4   Darkon   24b. Were autopsy findings available warminer? 1   Yes 2   No 3   Probably 4   Darkon   24c. Was an autopsy prior to completion of cause death? 1   Yes 2   No 3   Probably 4   Darkon   24c. Was an autopsy prior to completion of cause death? 1   Yes 2   No 3   Probably 4   Darkon   25c. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4   Darkon   25c. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4   Darkon   25c. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4   Darkon   25c. Was case referred to completion of cause death? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Club on the total to the cause of control of the cause of contr		0 0 0	sici	1 Yes 2 No			Month	Day Year
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25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	Ö	w req	iete			24a. Was an	24b. Were aut	opsy findings available
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27. Manner of Death   1	<u>ra</u>		<b>a</b>		26. Place of Deat		10 105	2 140
Duilding, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didle of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  31. Date filed (Month, Day, Year)  32 Registrar's Signature		nysici nis ce i direc			Other		ce 6 Other (Spec	ify)
Duilding, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didle of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  31. Date filed (Month, Day, Year)  32 Registrar's Signature	Ē	ng Pl		/Manth Mari Vacal Intra-		28d. Describe how	infury occurred	
Duilding, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didle of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  31. Date filed (Month, Day, Year)  32 Registrar's Signature	S	tendi Jeath. tor: A the fu	cati	2 Accident investigation				
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32 Registrar's Signature	$\leq$	or All after of Direction by	ertit	determined   286. Place of Injury - At nome, farm, st	treet, factory, office	City or Town,	et and Number or Hui State)	rai Houte Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32 Registrar's Signature		spital tours neral filled		29a. Certifier 1 Dertifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the caus	se(s) and manner as	stated.
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32 Registrar's Signature		hs Ho in 24 t hs Fu bletely	edic	(Check only 2   Medical Examiner: On the basis of examination and/or in	nvestigation, in my opinion, death occurr	red at the time, date	and place, and due	to the cause(s)
State 31. Date filed (Month, Day, Year) 32/Registrar's Signature		To t withi To ti	Σ	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month	, Dey, Year)
State 31. Date filed (Month, Day, Year) 32/Registrar's Signature		12		Kein Cic Soughes M	D 052862	-	2014	0,2007
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature						٥- لك	***	2300
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Registrar JUL 1 0 2007 Rose & Appelle				JUL 1 0 2007 Lineur & do	artie			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Simmons July 2007 Maxcine 4 1750 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery if Under 1 Year | If Under 24 Hrs. . Social Security Number 8. Date of Birth (Month, Day, Year) (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛛 F Director 577-58-7325 57 Oct. 20, 1949 Wash., DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 XYes 2 No Director Md. Montgomery Takoma Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20912 r Items 23a iner must b 7517 Blair Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 🔀 No Specify: 9 3 ☐ Widowed 4X Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 tt. Pages 1 and 2 su... Ament of Health and Mental 173, Ament of Health and Mental 173, Ament of Health and Mental 173, and 184, th Security Fed. Govt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie Battle Mary Hart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2681 Evans GA 30809

20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Health Important: If item 27 Sabrina Moore/daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 7/9/07 Riverdale, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee anna Hodoe 3910 Silver Hill Rd., Suitland, Md. 20746 23a. P. 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** FULMINANT HEPATIC FAILURG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPONATREM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trai Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HYPERKALGHIN 1 Yes 2 No 3 Probably 4 Unknown METASTATE BREAST CANCER Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an RESPIRATORY FAILURG autopsy perform page HYPER BILIRUBINGMIA 1□ Yes 2 1 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Iniurv 1 ☐ Yes 2 ☐ No investigation 2 Accident after death completely filled in by the

that the death certificate be executed and Box 68760. attending physician P.O. I been signed by the s should be detached Division or Vital Records. certificate

death.

Hospital of 24 hours at within 24 hours a

filed within 72 hours after death with

Saltimore, Maryland 21215-0036

Certification:

29a. Certifier

6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier M.D

D 59121

29d. Date signed (Month, Day, Year) 5/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIK TASNEEM 31. Date filed (Month, Day, Yea

7600 CARROLL AVENUE, TAKOMA PARK, MD 20912 32. Registrar's Signature

State Registrar

Medical

			For State Registrar	State o	of Marylan		artment of H rtificate of		nd Mental	, 0	ene g. No.	S 195 - 15	99030
T	<u> </u>		Decedent's Name (First, Middle)	, Last)						of Death	Tem -		3. Time of Death
ļ,	Physici		Jesse Lee Sp	ells					July		Day 4	2007	7:07 A M
	/Medic Examir		4a. Facility Name (If not institution		ımber)		4b. City, Town, o	r Location of I			4c. Coun	ty of Death	
			Prince George'	s Hospita	a1		Cheve	rly			Pri	nce Ge	orge's
	Funeral Director		5. Social Security Number 246-66-8443	6. Sex 1⊠ M 2□ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min. (Mon.	th. Dav. )	(ear) 1942	Cour	place (State or Foreign atry)
	D .		Usual Residence of Decedent										
	inylar show	_	10a. State 10b. County			y, Town or Lo						1	0d. Inside City Limits
	Ba-f s	ct	DC			Vashing							1 ⊠Yes 2 No
	or 2	Director	10e. Street and Number				10f. Zip Code			100		f What Cour	ntry?
	ath v	ra	5104 C Street,				200				USA		
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Marri 3 □ Widowed 4 □ Divorced	Armed F	2   No ive		Was Decedent of H If Yes, specify Cub I ☐ Yes 2☑ No	dispanic Origir an, Mexican, F Specify:	n? (Specify Yes Puerto Rican, et	or No- c.)		ace - Americ lack, White, cify: Bla	etc.
ğ	2 hol	Completed	15. Decedent			16a. Dece	dent's Usual Occup	oation	d weather.	16	b. Kind of	Business/Ind	
2	hin 72 ho e. an "natur Medical	lg	(Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	life. I	kind of work done OO NOT use retire	d) auring most o	or working				
2	filed withii Hygiene. other than ent, the M	5	12th			San	itation W				WSS		
b	0 7 5	Be (	17. Father's Name (First, Middle,	Last)					s Name (First, IV		aiden Surna	ame)	
Va	should be ind Mental marked o	၉	Unknown					Cle	o Eldric	ige			
lar	2 sho		19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Number	or Rural Route I	Number, (	City or Tow	n, State, Zip	Code)
	and ealth m 27 ner tr		Marcus Spells/	Son	lan e		South Da						
ore	. Pages 1 and 2 should be ment of Health and Ments tant: If item 27 Is marked jury or other traumatic e		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from	State 20b. F	Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date	20	Oc. Location	n - City or To	own, State
Baltimore,	. Ра tmen tant: jury		4 ☐ Donation 5 ☐ Other (S)	**	Way		orial Pa		-11-2007			oro, N	
ga i	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service	Licensee	۸ ۸		2. Name and Addre						
	⊕ □ = # O		9 PMa	rshal	<u> </u>		217 9th		·			n, DC	20011
	Physician /Medical		23a. Part / Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on a. Fat	each line.  al Card: (or as a conseq	iac Arı		ng, such as ca	ardiac or respira	ory arres			Approximate Interval Between Onset and Death
	Examiner				ertensi								
		je l	Sequentially list conditions, immorphisms. Cause. Enter Underlying Cause (Disease or injury				- 8	*					
	outed Id ansit	Examine	that initiated events	c. Cor	onary A	rtery I	)isease						
oʻ	a exectan an arrigital-ti	Ĕ	resulting in death) Last	Due to	(or as a conseq	uence of):							
68760,	cate be executed physician and the burial-transit	dical		d. Dia	betes								
.O. Box 6	that the death certific led by the attending p detached for use as i	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	atcome pf pregna birth 2 □ Feta nant at time of d nown	uldeath 3□	Ectopic pregnanc	у			1	Date of delive	ery Day Year
Δ.	es gu	by	Part II. Other significant condition	ons contributing to o	leath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e.				ne cause of death? pably 4 凶Unknown
00	w requir been si should	Completed							24a	Was an	241	Were auto	psy findings available
Re	The la ate has page 2	Ĕ							_	autopsy	ed?	prior to cor death?	mpletion of cause of
ā	(0 -	ပိ	25. Was case referred to medical					26 Place of	f Death (Check		X No	1 ☐ Yes	2 No
>	Physician: this certific al director,	Ö	examiner? 1 ☐ Yes 2⊠ No	Hospital:	Inpatient 2 🛛	ER/Outpatien	t 3 DOA Oth	er	ing Home 5□			thos (Cassif	
ō			27. Manner of Death	28a. Date	of Injury	28b. Time of					injury occ		<u> </u>
<u>0</u>	Attending r death. ector: After oy the funer	ţi	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	3	nth, Day Year)	Injury		Yes 2 ☐ No	,				
Division or Vital Records,	in Pitte	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	and Zee. Place	e of injury - At ho ling, etc. (Specif	ome, farm, str	eet, factory, office			tion (Stre		nber or Rura	al Route Number,
	ne Hospital n 24 hours a ne Funeral bletely filled	Medical		g Physician: To the Examiner: On the b and mar									
	To the within 2 To the complex	ğ	29b. Signature and title of certifier			0	29c. Licens				_	ned (Month,	
,	0			17	Lette	(	D58	957			July	6, 200	)7
1	(6)		30. Name and address of person	who completed cau	se of death (Iten	n 23a) (Type,	Print)						
	(F)		Gary Little		ospital		Cheverly	, MD	20785				
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Sign	e di							

DHMH 17 Rev 1/2001

		For	State of Ma		d / Depa	artment of H	lealth and N		_	lible.		
	_	State     Registrar			Ce	rtificate of	Death	R	eg. No.	IDE	5.4	231
Physicia /Medica	_	1. Decedent's Name <i>(First, Middl</i> e, <i>L</i> Martha	.ast) Mae		S	pitzer		2. Date of Dea Month July 1	Day	Year 7	3. Time of 5:37	of Death  A M
Examine		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location of Death		4c. Cour	ty of Death	1	
	ú	Memorial Hospit	a1				erland		A11	egany	<b>y</b>	
Funeral Director		213-40-3544		e (In yrs. I 66	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 06/17/1	, Year)	Cou	nplace (State untry) ryland	
and t	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside (	City Limits
Maryi -f sho ied a	į	MD Alle	ganv		Cu	mberland					1 XYes	s 2□No
r 28a	Director	10e. Street and Number	50			10f. Zip Code		1	0g. Citizen o	f What Cou	untry?	
filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	a a	449½ Columbia	a Street			2	1502		US <i>I</i>	1		
r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Dican, etc.)		ace - Amer lack, White	rican Indian, e. etc.	
s afte ; or it	by Fu	1 Never Married 2 Married	If Yes, Give	No		1 ☐ Yes 2 🏋 No	Specify:	,	Spec	cify:		
hours turai	D D	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		16a Dece	edent's Usual Occup	ation		16b. Kind of		White	
in 72 i "nai ledic	ete	15. Decedent's (Specify only highest of	grade completed)		(Give	kind of work done  DO NOT use retired	during most of worl d)	king	100. Killa ol	Dusiness/ii	ndustry	
with jiene. r thar the N	Completed	Elementary/Secondary (0-12)	College (1-4or 5	o+)		Homemak			Н	ome		
othe vent,	BeC	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	ne (First, Middle,	Maiden Surn	ame)		
Menta	0	Anthony	Joseph		Komat	Z	Ruth	S	erapta		Metz	
2 sho and is ma		19a. Informant's Name/Relationship				ing Address (Street					ip Code)	
and lealth m 27 her ti		John A. Spitzer,	Sr./ husba	_		1 Columbiosition (Name of		Cumber	land, 20c. Location		21502	
it of H		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3		C	emetery, cre	matory or other pla	ce)			•		
it. Pa rtmer rtant: njury	-	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	*	Eck		Cemetery 2. Name and Addre		3/2007			larylan	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ones.		21. Signature of Paneral Service Lic	ensee ()	1	I	404 Decat			•		21502	P.A.
	Н	23a. rart1. Enter the disease, or co shock, or heart failure. List on	emplications that	the death				· .		1.15	Approxima	ate
Physician		Immediate Cause (Final disease or condition									Onset and	d Death
/Medical		resulting in death)	a. METASTA Due to (or as								4 MON	THS
Examiner		Sequentially list conditions	b. —									
Ps #s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):							
be executed ician and burial-transit	xam	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):							
bur	a E											
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n certi	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			□ci			23d. I	Date of deli	very	
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at the by the	پر کار	9 ☐ Unknown										
res ti	2	Part II. Other significant conditions	s contributing to death b	out not resi	ulting in the t	underlying cause giv	en in Part I.		es 2∐No		the cause of	Unknown
requi	sted									7151	10010-1	
has t	Completed	_						24a. Was a autop perfor	sy 🖍	<ul> <li>b. Were au prior to c death?</li> </ul>	topsy findings completion of	s available cause of
n: Th ficate r, pag		25. Was case referred to medical						1 Yes	22 No	1 ☐ Yes	2□ No	
rsicia s certi	o Be	examiner?  1 Yes 2 No	Hospital: 1 Inpatie	ent 2□	ER/Outpatie	ent 3 DOA Oth	ner-	th <i>(Check only or</i> ome 5 ☐ Resid		thar (Sna	cifu)	
g Phy er this eral c	<u>ات</u>	27. May er of Death	28a. Date of Inju	ıry	28b. Time o			28d. Describe h			<i>y)</i>	
endin ath. or: Af he fur	atio	1 ✓ Natural 5 ☐ Pending investigat	ion	, , , , ,	,,		Yes 2 □ No					
or Atte ter de irecte n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of inj building, et	ury - At ho tc. (Specif	ome, farm, st	treet, factory, office		28f. Location (S City or Tow		nber or Ru	ıral Route Nu	ımber,
oitai c urs af erai D		00 - 0 - 455 - 4 The - 455 - 455 - 4	Shunial Table	of way len o	udadaa daa	th appropriate the ti					-4-4-4	
Hos 24 ho Fune etely f	Medical		Physician: To the best caminer: On the basis of and manner st	of examina								e(s)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director, After this certificate ha completely filled in by the funeral director, page	No.	29b. Signature and title of certifier	and many too do			29c. Licens	se number	- 2	29d. Date sig	ned (Month	h, Day, Year)	
5		1 //m	12			מת	67.66		July	11 ,	2007	
		30. Name and address of person w	no completed cause of d	leath (Iten	n 23a) (Type		0/00			-		
nes			924 SETON I			BERLAND	MD 2	1502				
Stat Registra		31. Date filed (Month, Day, Year)	2007 32. Registr	rar's Signa	ature	Joseph						
negistra	41 v	JOL II	TOO!	580 .	10.	A CHARLES						

**Physician** /Medical Examiner

**Funeral** Director

the Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at with 1 other 1 injury or other traumatic event, permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important; if item 27 is marked o

Saltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

and Records, P.O. Box 68760 attending physician certificate be as the use the Division or Vital this Atter the Hospital or Attending hin 24 hours after death. Director

9 109 3 2. Date of Death 3. Time of Death Month ALICE D. TREES 4:30 P. M 2007 Ju<sub>1</sub>y 6 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Cherry Lane Nursing Center Laure1 Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🙀 F 579-12-7949 90 08-24-1916 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits MD Prince George's Director Laurel 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 9001 Cherry Lane 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2√ No Specify: White \$ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stenographer Federal Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Albert Vernon Dickinson Jessie Eunice Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth K. Russell/Niece 9449 Arlington Blvd., #304, Fairfax, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/01/2007 Arlington, Virginia Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Mull Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): Anemia Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Chronic Lymphocytic Leukemia Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? General Disability 1 Yes 2 No 3 Probably 4X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 2**K** No 1 TYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 401 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0045217

State Registrar

24 hours a

within 2

30. Name and address of

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son who con

Isaac Kjayi, MD, 6201 Greenbelt Rd., #U15, College Park, MD

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

July 9, 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Honth** 10:12 AM **Physician** Thompson 2007 Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Lions Center Cumberland 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 ☐ M 2 🂢 F 92 217-10-5073 Feb 3, Director WV 1915 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 □ Yes 2 □ No Director MD Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 13521 Pershing Street 21502 Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 0wner Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Varner Delphia (Johnson) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , Cumberland, MD 21502 13521 Pershing St, SW Larry B. Thompson / son altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Hillcrest Burial Park 7/20/07 4 ☐Donation Cumberland, MD 21. Signature Fureral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. Cumberland, MD 21502 404 Decatur St., 23a. Part1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia Advunced **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 1∐ Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director; After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 30 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one)

2 ₹ 2

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3 MU

Registrar

State

31. Date filed (Month, Day, Year) 2007 JUL 18

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Tarn

29c. License number

		For State Registrar				nd / Depa		t of H	ealth a	and N	fental Hygi		007	23831;
		Decedent's Name (First,	Middle, La	st)							2. Date of Deat	1		3. Time of Death
Phys		Dotter Lou	Whit	te							Month July	Day 6	2007	4:45 A M
Exan	dical niner	4- FWN			mber)		4b. City,	Town, or	Location of	of Death	July	_	ounty of Death	
		918 Johnson	Stree	t			Sali	sbur	V				Wicomi	ico
Funer	al	5. Social Security Number	6. 5	Sex	7. Age (In yrs.	last birthday)		1 Year Days		24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	nplace (State or Foreign untry)
Directo	or	220-26-7815		1 □ M 2 □XF	75	Yrs.	IVIOTITIS	Days	Tiours		Oct. 16,	1931	l Mar	yland
pu &		Usual Residence of Deceder 10a. State 10b. C			10c Cit	ty, Town or Lo	cation			-				10d. Inside City Limits
sho	1													1 ⊠ Yes 2 □ No
the A	Director	Maryland   Wie	comic	0		Salisbu	T V 10f. Zip	Cada			14	a Citiza	n of What Cou	unta 2
with			n C+=	oot				1804				og. Okizei	USA	
within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	Finaral	918 Johnso	n su	1	edent Ever in U	IS 13			isnanic Ori	inin? (Sn	ecify Yes or No-	14.	Race - Amer	
fter d	1	1 Never Married 2	Married	Armed Fe 1 ☐ Yes	orces?				n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.
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filed wii Hygien ther th	٥			2		lab	orer-	sea	mstre	ess		Waln	nart De	ept. Store
be filed tal Hygi d other	B	17. Father's Name (First, M	iddle, Last	)							e (First, Middle, A	faiden Su	ımame)	
Ment Ment Marked	F	Edgie				Whi	te		Ma	aggie	9			Turpin
and and ie n		19a. Informant's Name/Rei	ationship (	Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rui	al Route Number,	City or T	own, State, Z	ip Code)
s 1 and 3 f Health item 27 other tr		William A. Pu	rnell,	Jr./ so	n and	918_	Johnso	n St	reet				21804	
S o I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem	ation 3	Removal from	State 200.	Place of Dispo cemetery, cre-	matory or c	ne or ther plac	(8)		Date	20c. Loca	tion - City or 1	Town, State
		4 □Donation 5 □Ot	ner (Specia	(y)		lisbury								Maryland
permit. Departi import	ġ	21. Signature of Funeral Se	rvice Lice	nsee (	00						-	Roa	d, Salis	sbury, MD
0 U ≥ €	OI .	Tarre	ul	n. A.	ney	Jo	olley	Mem	orial	Cha	pel, P.A.			21801
		23a. Part1. Enter the disea shock, or heart failure	se, or com List only	one cause on	caused the dear	th. Do not en	ter the mod	le of dyin	g, such as	cardiac	or respiratory arre	st.		Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition resulting in death)	23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line limited disease or condition											
/Medica Examine		resulting in death)	- (	Due to	(or as a consec	quence of):								
-4		Sequentially list conditions	any, leading to immediate Due to (or as a consequent a of):											
ted nsit	2	cause. Enter Underlying Cause (Disease or injury	′ ⊀	20010	(01 43 4 0011300	(4001120 01).	11							
xecu and al-tra	Fvaminer	that initiated events resulting in death) Last		c	(or as a consec	quence of):								
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death certificate be executed  e attending physician and id for use as the burial-transit	1	5		0.										
nding use a	1	IF FEMALE: 23b. Was decedent pregna	nt		tcome of pregn		7	-				230	d. Date of deli	very
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res that the de signed by the a be detached f	hy Dhyelelan/Madl	Part II. Other significant co	nditions	contributing to c	leath but not res	sulting in the u	inderlying o	ause give	en in Part I	l.	23e. Did tob	acco use	contribute to	the cause of death?
P P P P P P P P P P P P P P P P P P P				····							1 □ Ye	s 2 1	No 3□Pro	obably 4 Unknown
awre	100										24a. Was a		24b. Were au	topsy findings available
Physician: The lav this certificate has al director, page 2	Completed										autops perform	ned?	death?	completion of cause of
rtifica	9	25. Was case referred to m	edical				77 V		26. Place	e of Deal	h (Check only on		1 103	2010
ysici is ce direc	9			Hospital: 1 🗆	Inpatient 2	] ER/Outpatie	nt 3 🗆 DC	Oth	0.00	ursing He		***************************************	☐Other (Spec	cify)
ng Ph terth	9		Dendina.	28a. Date	of Injury oth, Day Year)	28b. Time o	it 2	28c. Injun Worl			28d. Describe ho			
ttendir death. ctor: Af y the fu	1	1 Natural 5 1 2 Accident	Pending nvestigation	on	,,,	,,	М		Yes 2	No				
er de recto	. mother of the or	3 Suicide 6 4 Homicide	Could not be determined	<ul> <li>28e. Plac</li> </ul>	e of Injury - At h ling, etc. (Speci	nome, farm, st	reet, factor	y, office			28f. Location (St. City or Town	reet and f	Number or Ru	iral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	3	5												
e Hospital 124 hours a Funeral letely filled	100	29a. Certifier 1 ☑ Ce (Check only 2 ☐ Mi	rtifying Pl	hysician: To th	e best of my kn	owledge, deal	h occurred	at the tin	ne, date ar	nd place,	and due to the carred at the time, da	use(s) ar	nd manner as	stated.
within 2.  To the Foundation of the Foundation o	Modlool	one)		and mar	nner stated.									
5 1 5 S		29b. Signature and title	enner	1			29	c. Licens	e number			90. Date s	signed (Monti	n, Dey, Year)
103		1					(		1206	114			1/9/0	27
Xa		30. Name and address of p	dison who	completed cau	ise of death (Ite	m 23a) (Type	Print)		C .		C .		. ^	/
`		31. Date filed (Month, Day,	Year	rahmo	1205 Registrar's Sign	rember	ton	x.	and	110	Ja(1)	bu	, MO	01801
	State istra	1111		2007	ita sign	alulo A.								
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** UAN WEPSEIC 07 /Medical 4a. Facility Name (If not institution, give street and numb 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring
H Under 1 Year | H Under 24 Hrs. Arcola Health & Rehabilitation Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Days Hours Min. Yrs. Director 061-28-9605 98 06/20/1909 Poland Usual Residence of Decedent worls 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 No Directo Silver Spring Montgomery 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 U.S.A. 1506 Leister Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: White 3 □ Widowed 4 □ Divorced ./ed v. ./al Hygiene. ~d other than "natu. ~t. Ine Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor Academia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental marked ۵ Unobtainable Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken Rosenau 1304 Rhode Island Avenue, N.W. Washington, DC 20005 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 ☐ Burial 2 CTCremation 3 ☐ Removal from State \* 4 ☐ Donetion 5 ☐ Other (Specify) 07/17/2007 Dale City, Virginia Potomac Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cunningham Funeral Home Ce 811 Cameron Street Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYJ NEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy ō in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by STAGE DEMENTIA 2 Na 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I firector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 -NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Abarsing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Hatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours aff To the Funeral Di completely filled in To the Hospitel 1 Learnitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of costifier 009834 who completed cause of death (Item 23a) (Type, Print) 20 FARRAGUT AUG. KENSING TON, MD 20895 ROSENISAUM 3720 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

9

USA

Specify:

Month

Salisbury Coastal Hospice At the Lake If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖫 F 80 Yrs Director 220-16-9375 10/11/1926 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Man, Department of Health and Mental Hygleins. In the Man Department of Health and Mental Hygleins "natural", or Items 23a or 28a-f sh Important: It flem 7 I is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified any Injury or other traumatic event, the Medical Examiner must be notified. Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 307 E. William St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Animal Hospital 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Ruark Otis Willey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1018 Sandstone Ct., Salisbury, MD 21804 Lori Simpson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a, Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 7/13/07 4 □ Donation 5 □ Other (Specify) Parsons Cemetery Salisbury, MD of Funeral Service Licens, 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 7 a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each the. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final Mota **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 pronths?

1 Yes 22 No
9 Unknown 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 TYes Completed 24a. Was an autopsy performed?
1 Yes X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 은 this Date of Injury (Month, Day Year) funeral spital or Attending Pt nours after death. neral Director: After the 27. Manner Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1. Decedent's Name (First, Middle, Last)

Kathryn W. Watson

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 2 No

1 TWes 2 □ No

0458AM

Year

14. Race - American Indian

white

Black, White, etc.

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Month

2 No

Maryland

07

4c. County of Death

Wicomico

State Registrar 4 ☐ Homicide

(Check only

29b. Signature and the of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of deat (Item 23a) (Type, Print)

Year)

29a. Certifier

To the Hospital o within 24 hours aft To the Funeral DI

coster

32. Registrar's Signature

🕊 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D26278

po Box 1733 Selity MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JUNE 2007 ear WARREN CHRISTOPHER WRIGHT 27 7:05 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7304 CLOVER DALE DRIVE OXON HILL PRINCE GRORGE'S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 577-82-0378 1 M 2 □ F 45 Yrs Director APRIL 20 1962 WASHINGTON, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1√2 Yes 2 □ No Director PRINCE GEORGE'S OXON HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7304 CLOVER DALE DRIVE 20745 Funeral U.S.A.

14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No <u>\$</u> Specify. BLACK 3 ☐ Widowed 4 ☐ Divorced er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER PRIVATE 12th 7 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked oth Be LEWIS ROSS 2 BETTY JEAN WRIGHT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7304 CLOVERDALE DRIVE ONON HILL, MARYLAND 20745 BETTY JEAN WHITE/MOTHER permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 7/6/2007 HARMONY CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on ... ch line. 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIVE to /Medical Due to (or a a consequence of): Examiner CAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) The law requires that the death certificate be executed US physician and s the burial-trans 2 Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate has 1□ Yes 2□ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA ۵ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or A within 24 hours after To the Funeral Dire completely filled in t

State

Registrar

Medical

29a. Certifier

29b. Signature

30. Name and addre

(Check only one)

31. Date filed (Month, Day, Year)



and manner stated

s of person who completed cause of death (Item 23a) (Type, Print)

1[X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

07

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month 3:00 AM CHARLOTTE BAUBLITZ WEIRICH 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Doctor's Community Hospital Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10-18-1915 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 □ M 2 🛛 F 91 Virginia 218-38-9760 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Adelphi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3210 Powder Mill Road 20783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther Edward Baublitz Margaret Windham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Lureau - Daughter 39th Avenue, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burjal 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 07-13-2007 Brentwood, Maryland 21. Signatur of Funeral Service Licentee 22. Name and Address of Facility 4739 Baltimore Ave. M01491 Gasch's Funeral Home, P.A. Hyattsville, MD 20781 1e pour 23a Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HIP FRACTURE 550 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): SPIN SHETIC Due to (or as a consequence of): DEMENTA 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes

**Physician** /Medical Examiner

nt of Health a

Department or Important: If any Injury or

Injury or other

**Physician** 

/Medical

Director

Funeral

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Completed

Be

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Examiner

**Funeral** 

Director

show

th and Montal Hygiene. ?7 is marked other than "natural", or flems 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

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death

1 and 2 should be filed within 72 hours after

Maryland 21215-0036

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altimore,

Pages

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical þ Completed Be မ

burial-trai attending physician for use as the buris sate has been signed by the page 2 should be detached in by the funeral director, Certification:

Hospital or Attending Physician: filled 24 hours a within 24 hou

To the Fune

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after death

State Registrar

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy Hy POTHY ROIDIST 1 BISERCE 25. Was case referred to medical examiner?

12 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 🗌 Yes 121,50 PM 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2007 SHE FOU IN HER ARMSTERS 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Tomp State) determined 4 ☐ Homicide | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) HILLITHER ASSISTED LIVING 29a. Certifier and manner stated. Grader 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) H0855 125550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE

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32. Registrar's Signa

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31. Date filed (Month, Day, Year) JUL 1 1 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day 1:00 PM Physician 5,2007 Danie1 Winfield une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lions Center for Nursing & Ext. Care **Allegany** Cumber land 6. Sex 1**X** M 2□ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. Months 06/06/1918 MD 89 214-05-9813 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryler Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director **Cumberland** Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 12501 Lisa Drive, NE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 K No Specify Specify: Completed by WWII 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Laborer 9 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Joseph Winfield Mary Anna (Himmer) Winfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2402 Patten Road, Harrisburg, PA 17112 Jo Ann Greise / Niece Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 06/18/2007 Flintstone, MD 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, PA 404 Decatur Street, Cumberland, MD 21502 -ch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final **Physician** Squamous Month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it arry, leading to infinite liant cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 physician the burial IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e 9□Unknown signed by the period of the details and the de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 No pege 2 : certificate 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 2 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending After 5 Pending investigation 1 Natural 2 Accident Injury n 24 hours after death. The Funeral Director: A bletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 20

Registrar
DHMH 17 Rev 1/2001

nes

30. Name and address of person w

Year) N 1 8

JUN

31. Date filed (Month, Day,

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

07-05308

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Sandra	Darlene	Wentling
Cariara	Dunono	1 TOTALINING

		1- For State Certifica Registrar	te of Death	riygici	Reg.	No.	n7 299k
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)     Sandra Darlene Wentling		2. Dat	e of Death		3. Time of Death 1520 hrs
Vicultai Exami	IICI	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	July eath	nth D y 10, 200	4c. County of	
X		RT. 220 North	Cumberland			Allegany	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	· · · · · · · · · · · · · · · · · · ·	N.C.		1:	9. Birthplace (State or Foreign
Director		216-40-3027 1 M 2XF 65  Usual Residence of Decedent	Yrs.	0	5/25/	1942	Country) MD
any		10a. State 10b. County 10c. City, Town of	or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once,	ō	MD Allegany Cumberl	and.				1 Yes 2 X No
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with the Maryland is 23a or 28a-f sho e notified at once		12137 Cash Valley Road, NW  11. Marital Status 12. Was Decedent Ever in U.S.	21502  13. Was Decedent of Hispanic Origin?	/ Canais . V	(aa aa Na	USA	A
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2 3	Completed	College (1-4 or 5+)	uring most of working life. DO NOT use	retired)			
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D 21 should and Mer 7 is man	٢		Mailing Address (Street and Number				
			2137 Cash Valley F Disposition (Name of cemetery,	Road,			ity or Town, State
Baltimore, permit. Pages I an Department of Hea important: If ites		1 X Burial 2 Cremation 3 Removal from State cremato	ry or other place)		1		
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Dep Dep Diri	6.8	Fabrit C. adams	404 Decatur Stre				
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	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
_ :	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
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68760 certificate b iding physic se as the bu		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pre	egnancy		23d. Date of de Month	alivery Day Year
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Divis To the Hospital or A within 24 hours after To the Funeral Dire	ledical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.					
	Ž	29b. Signature and title of certifier	29c. License number		- 1		(Month, Day, Year)
3		20 Name and address of names who considers:	O.C.M.E.			uly 11, 2007	,
nds			enn Street, Baltimore, MD 212	201			
St Regist		31. Date filed (Month, Day, Year) 32. Regionar's Signature	Loans				
		8					

07-05194 Abraheim Zarti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 6, 2007 1938 hrs Medical Examiner ABRAHEIM ZARTT 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Ft. Washington Medical Center Fort Washington If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 215-27-8330 1 X M 2 F JULY 29, 1985 Director 21 Country) HAWATT Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 X No show CHARLES MARYLAND BRYANS ROAD Director 23a or 28a-f s notified at on 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 20616 UNITED STATES 2420 BLACKBERRY COURT 14. Race - American Indian, Black, 11. Marital Status

1 X Never Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) jes I and 2 shoure ov ..... t of Health and Mental Hygiene. •• If ivem 27 is marked other than "natural", or item •• Medical Examiner must I Yes Yes 2 X No specify: Specify: BLACK If Yes Give Year Divorced 2 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 RETAIL 12TH GRADE MANAGER 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CATHY VEROUE JOHNSON ZARTI Be MOHAMED MAHDI ZARTI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) B YVONNE ZARTI / STEPMOTHER 2420 BLACKBERRY COURT, BRYANS ROAD, MARYLAND 20616 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) or other 1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY JULY 13,2007 CLINTON, MARYLAND Donation 5 Other Specify 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. ature of Fu Se in 11 en LIDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line √Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical physician a AMENDED LINPENDED requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live hirth Fetal death use as 1 past 12 months' Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown a Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ð Yes 2 ✔ No 3 Probably 4 Unknown ۵ Completed Records, 24b. Were autopsy findings available 24a Was an certificate has been prior to completion of cause of autopsy death? The law performed? No Yes 2 1 🗸 Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be Other<sub>4</sub> examiner? Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA this 1 V Yes 28a. Date of Injury Month, Day, Year Jul 6, 2007 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Operator of motorcycle that collided with a Certification: 1854 hrs Yes 2 V No Director: d in by the f Pending motor vehicle within 24 hours after death 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide or Town, State) Southbound Route 210, Fort Washington, Md. determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier O.C.M.E. July 7, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 31. Date filed (Month, Day, Year) strar's Signature

State Registra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	-	tificate of Death			leg. No	007	230	1, 2
	Physicia		1. Decedent's Name (First, Middle, Last)				Date of Dea     Month	th Day	Year	3. Time of E	Death
	/Medic		PAMELA LOUISE		ZEMBOWER		07	16	0.7	1125	M
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	f Death		4c. Cou	inty of Death	n	
			WMHS-BRADDOCK CAMPUS		CUMBERLAND			ALI	EGANY		
	Funeral		4DM 0DE	(In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. Min.	8. Date of Birtl	ı (_Year)_	9. Birth	nplace (State or	Foreign
	Director			1 Yrs.			Dec 9	1955	Maı	yland	
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation					10d. Inside City	/ Limite
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	Ba-f	Sch	MD Allegany	Cumber1a	7					71	
	or 2	by Funeral Director	10e. Street and Number		10f. Zip Code				of What Co. d Stat	,	
	ath v s 23a iust	<u>a</u>	11814 Bayberry Ave		21502						
	er de	nue	11. Marital Status 12. Was Decedent Ev Armed Forces?	/er in U.S.   13. V	Vas Decedent of Hispanic Orig f Yes, specify Cuban, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		Race - Amer Black, White	e, etc.	
2	or i	Ϋ́F	1 A Never Married 2 Married 1 Mes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	· .	Yes 2 No Specify:			Spe	ecify: Wh	ite	
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7	withir	립	Elementary/Secondary (0-12) College (1-4or 5+1)	Owne	*			Salo	n		
7	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ပိ	17. Father's Name (First, Middle, Last)	0		r's Name	(First, Middle,				
yianu	d be intail	Be	Elvin Lorraine Zembower							Zembowei	c
Ž	d Me mark matic	မ	19a, Informant's Name/Relationship (Type. Print)	19h Mailin	g Address (Street and Numbe						
<u>0</u>	d2s than 7 is t		Mary Louise Zembower / moth		5 Marsden Lane			-			
ָ ע	1 an Heal em 2		20a. Method of Disposition				ate		on - City or		
<u>5</u>	nt of nt of : If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		sition (Name of natory or other place)				-		
Dallino	it. Part rtant rtant njury		4 □ Donation 5 □ Other (Specify)  21. Signatur, of Fineral Service Licensee		d Crematory 7  . Name and Address of Facility				rland	-	Δ. Ι
o O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of numeral Service Licenside	1   "	404 Decatur S			-			
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	2.00	١.,	23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause ob each ine			Cardiac C	ir respiratory ar	rest,		Interval Betw Onset and D	veen
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	/Medical Examiner		Div to (or as a	consequence of):						unta	-DIAM'S
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	ed sit	ine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence or).							
_	and I-tran	Examiner	that initiated events c	consequence of):							
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Ľ	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use		Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.		23e. Did to	bacco use	contribute to	the cause of de	eath?
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VISIOII	ttenc leath tor:	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of injure	y - At home, farm, str			006  +: /6	``````````````````````````````````````		und Davida Alivert	
$\leq$	or A	Certification:	4 Homicide determined building, etc.	(Specify)	set, factory, office	1 '	City or Tou	n, State)	umber or HL	ıral Route Numl	oer,
_	pital ours a eral I		29a. Certifier 1 Certifying Physician: To the best of	my knowledge dost	a occurred at the time, data an	d place	and due to the	20100/2/ 2-	d mannar a-	etated	- 1
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	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29b. Signature and title of certifier		29c. License number		T	29d. Date si	gned (Monti	h, Day, Year)	
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	nes		30. Name and address of person was completed cause of dea	aun (item 23a) (Type,	Seton Dri	WP.	Cumh	orlan	dm	1 215	CO
	Sta	to	31. Date filed (Month, Day, Year) 32. Registar	's Signature	261011 1011	V _ /	LUHIU	SILUIT	11111	0, 013	) ()
	Sta		1311 4 0 0007								

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 11 71 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 1230 PM Joseph Frank Alascia, Jr. July 22 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 19, SAINT AGNES 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1949 1**12** ★ 2 F 216-52-9415 57 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll 1 ☐ Yes 21 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3343 Marston Road 21157 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXXVo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Barber Sams Barber Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Frank Alascia, Sr. Margaret Alice Burger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lisa Bierman Sister 2171 Timothy Drive Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Ebenezer Ch. Cemetery July 26, 2007 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burrier-Queen Funeral Home & Crematory, Var1. Inter the disease, or complications that cursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on sach line. 21784 Winfield, MD Approximate Interval Between Onset and Death nediate Cause (Final ease condition ultin in death) Dulmonary day Due to (or as a consequence of): ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ 7es 2 ☐ No 24a Was an autopsy performed? Yes 2 ☐ No 11 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner Examiner

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Baltimore,

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Vital

or

Division

or Attending Physician:

Hospital

Pages 1 permit. Page Department of Important: If any Injury or 6

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Be Completed by Funeral

**Funeral** 

**Director** 

"natural", or items 23a or 28a-f show dical Examiner must be notified at

filed within 72 hours after death with the Maryland

Physician/Medical as for 1 24 hours after deal e Funeral Director

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Completed

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Medical Certification: To

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examiner? 1 ☐ Yes 2 ☐ No	)
27. Manner of Death	

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

28a. Date of Injury (Month, Day Year)

28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 ☐ Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

D0056143

29d. Date signed (Mgnth, Day, Year)

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of Person who completed cause of death (Item 23a) (Type, Print)
W. RAYMOND ZHU, DEPT. PATHOLOGY, STIAGNES HOSPITAL, 900 CATON AVE

State Registrar



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21215-0036	ld be f fental narke event	o Be	Kenneth	Name/Relation	TIISOI	Print )		19b. Mai	ling Address (	Street and Num	ber or Rural F	Route Numb	er, City or	Town, State	e, Zip Code)	1
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Division of Vital Records. P.O.	the Hospital or Attending Physician: The law requires that the death him 24 hours after death.  the Funeral Director: After this certificate has been signed by the arter.	F 5		2 No		28a Date	of Injury			8c. Injury at Wo	ork? 28	d. Describe	how injury	occurred		
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_	Hospit 4 hour Funer				ng Physiciai	n: To the bes	st of my know	ledge, death	occurred at the	time, date and	place, and du	ie to the cau	se(s) and i	manner as s e, and due to	stated. o the cause(s)	
	To the Hospital or A within 24 hours after To the Funeral Dire	completely	one)			In the basis and manner s	of examination stated.	n and/or inve	estigation, in my	. License numb			29d. Da	ite signed (	Month, Day, Year)	
	To To	5	29b. Signatur	e and title of co	ertifier				290	O.C.M.E.	-		1	19, 2007		
	•		4		/					J.J.IVI.L.						
10	OCI	AE		address of pe		ompleted cau	se of death ( Medical E	tem 23a) xaminer	111 Penn	Street, Balti	imore, MD	21201				
10				Ripple MI		244			rest 1							
	Rec	Sta jistr		MULDa2	3 200	Sta	egistrar's Sig	C. 19								

			1- State of Marylai Registrar		artment of Hea r <i>tificate of De</i>		ntal Hygier Reg. I	1111	23345
1	Physici	an	1. Decedent's Name (First, Middle, Last)			2.	Date of Death Month	Day Year	3. Time of Death
	/Media	cal	MARIE BARBARA AMOSS  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	ation of Death		23 2007 4c. County of Deat	4:43 P M
	Examir Funeral Director	ier	STELLA MARIS HOSPICE         5. Social Security Number       6. Sex       7. Age (In yrs         215 - 09 - 8488       1 □ M 2 □ x F       93	s. last birthday) Yrs.	TOWSO	N Under 24 Hrs. 8. ours Min.	Date of Birth (Month, Day, Yea	BALTIM 9. Birt Co	
	land ow t		Usual Residence of Decedent     10a. State   10b. County   10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sho fied a	tor	Maryland Baltimore	Baltin	nore County				1 ☐ Yes 2 🔀 No
	ith the or 284 oe not	Director	10e. Street and Number	Darozii	10f. Zip Code		10g. (	Citizen of What Co	untry?
	s 23a nust t	eral	5010 Shirleybrook Avenue	110	21237			JSA	des la disc
$^{M}\cdot$ Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced  12. Was Decedent Ever in UArmed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	-	Was Decedent of Hispar If Yes, specify Cuban, M 1 □ Yes 2 ☑ Ⅺ Sp	nic Origin? (Specifi lexican, Puerto Ric pecify:	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
15-0	יל 27 ר "natu edical	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done durin DO NOT use retired)	n g most of working	16b.	Kind of Business/	Industry
72.	filed withir Hygiene. other than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) N/A	me. L	Clerk		1	Two Guys	
pu	al Hyg l other	BeC	17. Father's Name (First, Middle, Last)			Mother's Name (F			
ylaı	2 should be f and Mental b is marked ot raumatic ever	입	Joseph Diepold				ret Endre		
M. Mar	s 1 and 2 should f Health and Mer ttem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and I			000-0	Zip Code)
	s 1 and 2 of Health a item 27 is	-	Robert Amoss (Son)  20a. Method of Disposition 20b.	Place of Dispo	Chestnut Di sition (Name of matory or other place)	rive Brac		23919 Location - City or	Town, State
:43 imo	Pages nent of l ant: If its ury or o	-			of Faith	7=27=0	)7 Ba	ltimore,	Md.
4:43 P. Baltimore,	permit. Pages Department of Pinportant: If ite any Injury or of once.		21. Signature of Funeral Service Licensee	L 22	2. Name and Address of assahn Fund	Facility eral Home	) 	14 01000	
	0.0		23a. Part1. Enter the disease or complications that caused the dea shock, or heart failure. List only one cause on each the	ath. Do not ent	er the mode of dying, su	uch as cardiac or re	espiratory arrest	)  0. 212 <del>3</del> 6	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	27703	2/404/2	15:21		3500	Onset and Death
7	/Medical Examiner		Due to (or as a conse	quence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	queries of):				100	
V	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last						
,09	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or as a consec	quence of):					
68760,	tificate I g physia as the k	edical	d						
3, 200 O. Box	aath cer attendin for use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ 100 9 ☐ Unknown  23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3□	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	w requires that the di been signed by the should be detached	oy Pt	Part II. Other In ant conditions contributing to death but not re-	sulting in the ur	nderlying cause given in	Part I.	23e. Did tobacc	o use contribute to	the cause of death?
JULY ords,	requir een si ould b	ted	Leading Hoom	6	is/se		1 Tes	2 No 3 Pr	obably 4 (IDDxnown
SS JULY Vital Records,	The la ate has page 2						24a. Was an autopsy performed 1∐ Yes 2	prior to death?	atopsy findings available completion of cause of
Vit	rslciar s certif lirector	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpatier	Othori	Place of Death (C		a 🗆 a	***
AMOS.	ig Phy ter this neral o	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury			J. Describe how in	6 ☐Other (Specially)	city)
SIO	tendir eath. or: Af the fur	atio	2 Accident investigation		M 1 ☐ Yes	2 □No			
MARIE Division	il or Attending Physician: after death. I Director: After this certification by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At he building, etc. (Spec	nome, farm, stre ify)	eet, factory, office	28f.	Location (Street City or Town, St	and Number or Ru ate)	ıral Route Number,
	To the Hospital or Attending Physician: within 24 hours after cleath.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  Check only one)  Con the basis of examination and manner stated.	nowledge, death	n occurred at the time, d vestigation, in my opinio	date and place, and on, death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of Certifier	n	29c. License nur	mber 3507	2	Date signed (Mont.	
	9					220/	2	7-24	07
	.1		30. Name and address of person who completed cause of death (Ite EDDIE NAKHUDA, M.D. 2300 DUI		Print) ALLEY ROAD	TIMONIU	M, MD 21	093	
and the second	Sta Registi		31. Date filed (Mon Day, 2a5 2007 33 Registrar's Sign		ale				

4:43 P.M.

		1 - State Registrar Amend 2,29d,p							Reg. No		1,2381
Physicia	an	1. Decedent's Name (First, Middle, La.  JANE	st)			ADA	MS	2. Date of De		y Year	- C 14
/Medic		4a. Facility Name (If not institution, giv	e street and number)		14		Location of Death	JUME	23	County of De	1302
Examin	er	THE JOHNS HOPKINS	,				RE CITY		1	. County of De	aui
Funeral Director		5. Social Security Number 6. S		(In yrs. last bir	thday)	f Under 1 Year Months Days		8. Date of Bir (Month, Da May 29			irthplace (State or Foreign Country) ryland
and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Locat	ion					10d. Inside City Limits
/anyle	ō	Maryland Baltimo		Balti		1011					1 ☐ Yes 2 🖫 No
the N 28a- notifi	rect	10e. Street and Number		Daiti		10f. Zip Code			10a. Cit	tizen of What (	41
th with	al Di	1409 Dorchester A	venue			2120	7		USA		•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 Yes 2 No				ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	)-	Black, Wh	
ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 1	Yes 2⊠ No	Specify:			Specify:	White
72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra		16a. 	Deceden	t's Usual Occup d of work done	ation during most of word d)	king	16b. K	(ind of Busines	s/Industry
within ene. than he Me	duc	Elementary/Secondary (0-12)	College (1-4or 5+	-)		emaker	1)		0,	wn Home	
filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last	· · · · · · · · · · · · · · · · · · ·				18. Mother's Nam	ne (First, Middle	L.,		
lid be fental rked c	To B	William James Ga	lloway				Vera Tw	ittv			
should be should		19a. Informant's Name/Relationship (		19b	. Mailing A	Address (Street	and Number or Ru		er, City	or Town, State	, Zip Code)
and 2 salth an 27 is		Thomas A. Adams	Husb	and 14	09 D	orchest	er Avenue	e; Balti	more	e, Mary	land 21207
ages 1 ent of He nt: if iten y or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		20b. Place of cemeter Metro	ry, cremat	ory or other plac	ce) 7/27/	Date / 2007		ocation - City o	e, Maryland
permit. F Departm Importar any injui		21. Signature of Funeral Service Lice	nsee			-					•
20 <b>2 2 9</b>		*COVIN	MO129		163	0 Edmon	dson Aver	nue; Cat	ons	ville,	ab Witzke MD 21228
		23a. Part1. Enter th / dilease, or com shock, or hear failure. List only	plications that caused to one cause on each line	the death. Do r e.	not enter t	the mode of dyin	ig, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Funga	1 Priceir	nonic	<u> </u>					Inonth
Examiner			Due to (or as a		,	ous Leu	Kemice.				9 worths
*	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	consequence	у		1471100				IMOFUVIS
cuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6								
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ertific ding p	Med	IF FEMALE:	220 If use suteems a	of programmy							
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal death		ctopic pregnancy ther (specify)	<u>'</u>			23d. Date of d Month	elivery Day Year
s that ned b	by Pr	Part II. Other significant conditions	contributing to death bu	t not resulting ir	n the unde	erlying cause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
w requires that been signed b should be deta								1 🗆	Yes 2	No 3□	Probably 4 □Unknown
law re as bee 2 sho	Completed							24a. Was		24b. Were	autopsy findings available
	mo							auto perfe 1□ Yes	psy ormed? 2 <b>X</b> No	death'	
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea				
Physic this co	2	1 ☐ Yes 2 No	Hospital: 1 Inpatien				4   Nursing H	ome 5 ☐ Res	idence	6 □Other (Sp	pecify)
or Attending Physician: ifter death. Director: After this certifica in by the funeral director. I	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day		Time of Injury	28c. Injur Wor		28d. Describe	how inju	iry occurred	
death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not b	e 28e Place of injur	ry - At home fa	arm street		Yes 2□No	29f Location	Street	nd Number or	Rural Route Number,
after after I Direct d in by	Certification:	4 Homicide determined	building, etc.	. (Specify)	2111, 511001	, idotory, omoc		City or To	wn, Stat	e)	nurar noute ivumber,
To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After bompletely filled in by the funeral or the funeral bompletely filled in by the funeral bompletely filled in by the funeral barbaral barb	Medical C	29a. Certifier (Check only one)  Certifying Properties of the control of the cont	nysiclan: To the best of miner: On the basis of and manner state	examination an	e, death o	ccurred at the tir stigation, in my c	me, date and place opinion, death occu	, and due to the irred at the time	cause(s	s) and manner nd place, and d	as stated. ue to the cause(s)
To t Withi	Ž	29b. Signature and title of certifier  **Eurology** (4)	Plonso, Ma	DICAL DO	CTOR	29c. Licens	e number		29d. Da	ate signed (Mo	nth, Day, Year)
5		30. Name and address of person who	G TAMAIC WOOD	iale wasa.	ITA.	EMAGRADI	Wall o Chan	i RAITII			
Sta	te	CAROLYN A LONSO, THO 31. Date filed (Month, Day, Year)	32. Registra	r's Signature	ارسا ۱۱۸	- Neigri		, -3116111	TORE	, winge	IVD OFF
Registr		31. Date filed (Month, Day, Year)	2007	الكر ما	Popula	well ?					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Frances Α. Brooks 19 2007 1947 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JH Bayview Baltimore MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1□M 2□F Director 220-30-4233 72 12-23-1934 Md Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Md. 1 Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 20th Street 729 E. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Schools Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Pulbic Supervisor 12th grade Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fredella Stevens Ollie Boone Jack 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 729 E. 20th Street, Baltimore, Md. 21218 Amelia A. Brooks Daughter Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-25-07 Baltimore, Md. Greenmount Cem. 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Grafe Millar March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARDID FULMONARY /Medical Due to (or as a consequence of): **Examiner** Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1∐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1√0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760, or Attending Physician: s after dec.

within 24 hours To the Funeral

State Registrar

Medical

31. Date filed (Month, Day, Year) 5

3□ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

6 ☐ Could not be

MS 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

33rd Jr # 136

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 5:10 PM 2017 Juanita Noreen Brimigion 19 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel Anne Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Month, Day, Year) 07/16/1941 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 X F 217-38-2240 66 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 236 Hickory Point Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify þ White 3 Widowed 4 ☐ Divorced Completed i and Mental Hygiene.
is marked other than "naturaumatic event, the Medical" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Account Engineer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental John Mack 2 Adelaide Burns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Anthony Shew / Son Avenal Road, Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 07/23/07 Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subarachnoid 11 hours **Physician** Hemorrhage disease or condition resulting in death) /Medicai Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Examiner certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9□Unknown 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2[**X**No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe this certificate 2 **X** No 1 ☐ Yes 2 ☐ No or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ို 27. Manner of Duath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural
2 Accident Injury 5 Pending investigation (Month, Day Year, 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FO \$252843

10

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

Division or Vital

Brimigion,

State Registrar

Medical Center

Washington

32. Registrar's Signature

Messer

M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore

Sangjin Oh

31. Date filed (Month, Day, Year)

JUNE

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#22, perFH C869, 7/25/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 4:25 AM Annie L. Bridgers July 20,2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/AJoseph Richey Hospice Baltimore If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
N. Carolina 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 💢 F Months Hours Min. 68 238-64-8571 1-14-1939 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. inside City Limits 1 Yes 2 No N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 N. Woodyear Street 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Balto City School  $1\dot{2}$ Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Howard Annie Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrina Burroughs Daughter 1203 N. Woodyears Street, Baltimore, Md. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Western Cem. 7 - 27 - 07Baltimore, Md. 22. Name and Brothersy Estep Brathers 21. Signature of Funeral Service License Estep Brithers Funeral Ser, P.A. 1300 Eutaw PLace, Baltimore, Md. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC CANCINOMA LUNG Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Street (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

**Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Md.

Funeral Director

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Completed

Be 2

Examiner

Physician/Medical

Be Completed by

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Certification:

Medical

attending physician and for use as the burial-trar

s certificate has b irector, page 2 sl

After 1

within 24 hours after death

To the Funeral Director:
completely filled in by the

director,

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a once.

Baltimore, Maryland 21215-0036

State Registrar

TSHIM 31. Date filed (Month, Day, Year)

JUL 2 5 2007

29b. Signature and little of certifier

29a. Certifier

SHALMY, MD. 6565 N. CHANCES ST Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DB44

MD DIMSICION

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

10022235

29d. Date signed (Month, Day, Year)

4 6310, BARRON, UD 21204

120/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BENNETT 2:26 AM MELVINA 23 JULY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** n/a Union Memorial Hospital 8. Date of Birth OCt. 21,1942 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours South Carolina 1 □ M 64 249-74-3654 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It has 12 is marked other than "natural"; or items 23a or 28a-f show other than "natural"; or items 23a or 28a-f show cother traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 U.S.A. 626 Debaugh Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: African American 1 ☐ Yes 2 🗓 No Specify ģ 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Religious Community Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosetta Chavris Lee J. Bennett Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun 6401 N. Charles Street Baltimore, Maryland 21212 Sr. Bernice Feilinger, S.S.N.D. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7-28-07 Villa Maria Cemetery Glen Arm, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature of Funeral Service 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final upper 8 lower GI Physician day disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner lung & liver methosta Gequentiany net conuncins, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed c. Adeno Carcinoma certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 12 No Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **№** No 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) Injury 1 Matural 5 Pending To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT2438946 JULY/23/2007 M.D

Registrar

31. Date filed (Month, Day, Year)

Nazi Farsi, MD

32@egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



union Memorias

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 1725 PM Biernack Martin Julu 2007 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bulhmore Medical Center Johns Hopkins Bayview If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days 1 ☑ M 2 🗆 F 213-68-5039 Oct. 2, 1956 Maryland Director 50 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rient of Health and Mental Hyglene. and the file 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2x No Catonsville Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA Funeral 1106 Edmondson\_Avenue 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specity: White ρ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Mason Masonry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norbert Biernack Lola B. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 1106 Edmondson Avenue; Catonsville, MD 21228 Dorothy Biernack 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 7/24/2007 Metro Crematory Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Day Stroke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Calescans of Figure ( Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last g physician and as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9☐Unknown 9 I Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy performed 2 **□** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29

within 24 hours after death.

To the Funeral Director; After congletely filled in by the funeral

b. Signature and title of certifier  Mo	29c. License number  RSS-000	29d. Date signed (Month, Day, Year)  July 20, 2007									
Name and address of person who completed cause of death (Item 23a) (Type, Print). Yolanda Chik 4940 East (M. Ave	enu Baltmare,	MD 21224									

State Registrar

3 Registrar's Signature 31. Date filed (Month, Day, Year)

29

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Devel 1

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	•	Certificate of			eg. No.	13850
	Physic	an	Decedent's Name (First, Middle, Last	•	7		-	2. Date of Deat Month	Day Year	
-	/Medi Examir		Roland Temp 4a. Facility Name (If not institution, give		, Jr.		4b. City, Town, or	July 24 Location of Death	+, 2007 4c. County of Dea	10:00 AM
4	LAGITI	ICI	College Manor				Luthery		Baltimo	
	Funeral Director		217-09-4192	KIM SIJE	e (In yrs. last birt	hday) If Under 1 Ye Months Da	ar If Under 24 Hrs	8. Date of Birth	Yeer) 9. Bi	country) aryland
	yew w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	· · · · · · · · · · · · · · · · · · ·	W II		10d. Inside City Limits
	e-f sh	tor	MD Baltimore Lutherville							1 □ Yes 2 🛣 No
	if the 28	Direc	10e. Street and Number			10f. Zip Cod	е	1	0g. Citizen of What C	ountry?
	s 23e	rai	608 Goucher Ave			2109			USA	4
020	d 2 should be filed within 72 hours after death with the Maryland th and Mentel Hygiene. 7 Is marked other then "netural", or Items 23s or 28e-f show treumstic event, the Macical Examiner must be rotified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1XXYes 2 □ N If Yes, Give Year or Dates:	Everin U,S. Io WW II	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (S luban, Mexican, Puerl No <i>Specify:</i>	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify:	erican Indian, ite, etc. White
2-0	72 hou		15. Decedent's Ed	ucation	16e.	Decedent's Usual Oc	cupation	dila	16b. Kind of Business	s/Industry
Baltimore, Maryland 21215-0020	ed within 7 giene. er then "r t, the Med	To Be Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	+) Ma	(Give kind of work do life. DO NOT use rel BNAGET	ne aunng most of wol ired)	King	Cemetery	4
and	be file of offh	Be (	17. Father's Name (First, Middle, Last)	lumber Co				ne (First, Middle, M		
ξ	should be that the short of the	ို	Roland Templar E	· · · · · · · · · · · · · · · · · · ·	19h	Mailing Address (Str.	Viola		eth Eidma City or Town, State,	
Ma	nd 2 salth ar 27 is r treu		Roland T. Burke,						, Maryland	
ore,	Peges 1 and 2 ment of Health a ant: If Item 27 Is ury or other tre	3	20a. Method of Disposition		20b. Place of	Disposition (Name of v, crematory or other p			20c. Location - City of	
Ĕ	Peg ment ant: If ury o		1 ☐ Burial 2 ☑ Cremation 3 ☐ i 4 ☐ Donation 5 ☐ Other (Specify)			p Svc. Cor		07/25/07	Towson, I	Maryland
Ball	permit. Peges Depertment of Important: If It eny Injury or once.		21. Signature of Funeral Service Licens	see	<sup>22. Name end Address of Facility</sup> Ruck Towson Funeral Home, In 1050 York Road, Towson Maryland 21204					
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lin	the death. Do n				•	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition			o vesa				Onset and Death
	_xamiino.	-	resulting in death)	ſ	Due to (or as e c	onsequence of):	, and a graph of the control of the			
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to o	Physician: r this certific rel director,	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 L Inpatien	t 2 ☐ ER/Out	patient 3L DOA		ome 5 Resider	nce 6-Other (Spe	ncify) Mano-
ion	Attending or death.  Sector: After by the fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) In	jury W	ork? □ Yes 2 □ No	Edd. Describe no	w injury occurred	-
Divis	al or Atter s effer des I Director od in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, feri (Specify)	m, street, factory, offic	е	28f. Location (Str City or Town,	eet end Number or R , State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funerel director,	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physical Exami	sician: To the best of ner: On the besis of a and menner state	examination end	death occurred at the for investigation, in my	time, date and place, opinion, deeth occur	end due to the ca red et the time, da	use(s) and menner a te end place, and due	s steted. e to the cause(s)
	e mit	Σ	29b. Signature and title of certifier	\	.1.		nse number		d. Date signed (Mont	th, Day, Year)
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10	5+1		30. Name and address of person who co	reine	MO	Sype, Print) 2/ W	2473 Jest Ru	0.700	won,	ND 21204
	Sta Registra		31. Date filed (Month, Day, Year)  JUL 2 5	32. Redistrar	r's Signature	had.	*			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2001 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Pate of Birth Month, Day, Ye Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ural", or items 23a or 28a-f shov | Examiner must be notified at 1 X Yes 2 □ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Widowed 4 Divorced "natural", Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LW . Pages 1 and 2 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 K Burial 2 ☐ Cremation 3 ☐Removal from State 200 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Home North 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final disease or condition resulting in death) **Physician** lyocardia /Medical Due for as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ed by the attending physician and detached for use as the burial-tran to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2□ No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Certification: To Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

P.O. Box 68760, Division or Vital Records, within 24 hours after death To the Funeral Director: Hospital the

> State Registrar

DHMH 17 Rev 1/2001

(Check only

one)

29b. Signature and

title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Pint)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

		-	For State State Registrar	-	artment of Health and Mertificate of Death		ene g. No.	7 23055
8	*		1. Decedent's Name (First, Middle, Last)		7	2. Date of Death		3. Time of Death
	Physicia /Medic		Albert Jo	La B	ARNES	July.	22 200	
	Examin		4a. Facility Name (If not institution, give street and	_	4b. City, Town, or Location of Death	1	4c. County of D	
			2508 Claret	Prive	) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		RFOLD Birthplace (State or Foreign
0	Funeral		5. Social Security Number  6. Sex  1 ☑ M 2 □ F	7. Age (In yrs. last birthday,	Months Days Hours Min.	(Month, Day,	Year) 9.	Country)
AA	Director	+	Usual Residence of Decedent	0 2		DEC 17, 1	1927 /	41114/1ANS
	how at		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside Cify Limits
	e Ma 3a-f s tiffied	cto	MARYLAND HARFURD	FA	-115toN			1 □ Yes 2 🕱 No
	ith th	Dire	10e. Street and Number	2110	10f. Zip Code	10	g. Citizen of What	Country?
	s 23a	Funeral Director	2508 Claret Dr	ecedent Ever in U.S. 13.	21047	acify Vas or No-	14. Bace - A	merican Indian,
	ter de	Fun	1 □ Never Married 2 K Married 1 □ Ye	s 2/R No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto	Rican, etc.)		/hite, etc.
920	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by	If Yes,	Give Dates:	1 ☐ Yes 2 No Specify:		Specify:	White
က်	dic dia	Completed	15. Decedent's Education (Specify only highest grade complete	d) 16a. Dece	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 1	16b. Kind of Busine	ess/Industry
21	within ene. than " he Mec	ğ	Elementary/Secondary (0-12) College	(1-4or 5+)	Chemist	ı	4.5.60	veryment
	e filed val Hygie other t		1Z 5	+	18. Mother's Name			
an(	<b>Ω</b> # <b>D</b> Φ	o Be		BALANOW				Kowski
Maryland	d 2 should th and Mer 7 is marke traumatic	ဥ	19a. Informant's Name/Relationship (Type. Print)		ling Address (Street and Number or Rur		City or Town, Star	te, Zip Code) 2/047
ğ	れまるよ		June S. Barnes	250	08 Claret Dri	ve FA	1) ston,	YARYLAND
ore,	es 1 and of Healt i Item 2 r other		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □ Removal from the second se	20b. Place of Disp cemetery, cre	position (Name of ematory or other place)		20c. Location - City	<b>M</b>
<u><u>Ë</u></u>	mit. Pages bartment of l cortant: If It		4 Donation 5 Other (Specify)	- ACDENS	OF FAITH July	26,2007 1	BAltim	ore, MARYLAND
Baltimore	permit. Departiments Imports any Inj once.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility	Jr. Fun	use Hor	ue
	<u>0</u> □ = # 0	A	23a. Part1. Enter the disease, or complications the	reno	263 5. CONKING	3+ DA	HO MD	2)22+ Approximate
	· · · · · · · · · · · · · · · · · · ·		shock, or heart failure. List only one cause of mediate Cause (Final	n each line.	inter the mode of dying, such as cardiac	A S .	T'an	
	Physician /Medical		disease or condition resulting in death)	to (or as a consequence of):	course of	1.s		Menus  Menus  Menus  Menus  Menus  Menus
	Examiner			to (or as a consequence or).	Hond	le si	ese_	- years
	100	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	to (or as a consequence of):				1
8.	death certificate be executed e attending physician and id for use as the burial-transit	Examiner	that initiated events c.					
ő	ie exe		resulting in death) Lest Due	to (or as a consequence of):				
68760	icate b physic the b	dical	d					
×6	leath certific attending p	Physician/Med	IF FEMALE: 23c. If yes,	outcome pf pregnancy			23d. Date of	delivery
Box	death atter	ciar	in the past 12 months?	egnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
O.	that the de led by the a detached i	hysi	9 ☐ Unknown 9 ☐ Ur	known				
s, P	The law requires that the ate has been signed by thoage 2 should be detache	by P	Part II. Other significant conditions contributing t	death but not resulting in the	underlying cause given in Part I.			te to the cause of death?
ord	w require been si	ted I	Will be	a a	2005	1 □ Ye	es 2 No 3	Probably 4 hknown
Records,	has be je 2 sh	Completed				24a. Was ar autops	24b Wer	e autopsy findings available to completion of cause of
_	: The	S				perform 1 Yes 2		h? Yes 2 No
Vital	Physician: Th this certificate ral director, pag	æ	25. Was case referred to medical examiner?		Other:	h (Check only on		
o	Phys r this ral dir	<u>د</u>	TLI fes ZIETIO	☐ Inpatient 2 ☐ ER/Outpatient et of Injury 28b. Time	elit 3 DOA 4 Nursing Ho		ence 6 Other (	Specify)
O	Attending F r death. ector: After by the funera	tion	1 ☑ Natural 5 ☐ Pending (A 2 ☐ Accident investigation	fonth, Day Year) Injury			,,	
Division	Attend r death ector: A	fica	3 Suicide 6 Could not be 28e. Pl	ace of injury - At home, farm, s illding, etc. (Specify)	street, factory, office	28f. Location (Sti	reet and Number of	r Rural Route Number,
Ö	tal or s afte al Dir ed in l	Certification:	4_Hornicide	illiding, etc. (Specify)		Oily Of TOWI	i, State)	
	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical Examiner: On the		ath occurred at the time, date and place investigation, in my opinion, death occu			
	To the hwithin 24 To the F complete	Medical		nanner stated.	29c. License number	20	9d. Dete signed (N	forth Pay Year)
	Vait Cor	-	29b. Signature and title of certifier	-110	000830		July	24 200)
			30. Name and eddress of person with confidence	ause of death (Item 23a) (Type	Teld Galley		07	- 1 200/
	10		30. Name and eddress of person with completed of	LIII	Wishin 2	1271	~ >1	
	-		31. Date filed (Month, Day, Year) 3	Registrar's Signature	1 10 11	-	-	
	Sta	ite		wer D. A.	ante),			

			1 - For State Registrar	e of Maryland / Dep <i>Ce</i>	artment of Health rtificate of Death		ntal Hygie	Ive to a f	2, 855		
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     HARRY     4a. Facility Name (If not institution, give street as	nd number)	BARON  4b. City, Town, or Location		Date of Death	Pay 2007 4c. County of Death	3. Time of Death  7 40 M		
	Funeral Director		JEWISH CONVALESCENT C  5. Social Security Number 099-03-6538  Usual Residence of Decedent	7. Age (In yrs. last birthday,	BALTIMORE  If Under 1 Year If Under  Months Days Hours		Date of Birth (Month, Day, Ye		E ace (State or Foreign ry)		
	ath with the Maryland 23a or 28a-f show	ector	10a. State 10b. County N/A	10c. City, Town or L BALTIM				10	od. Inside City Limits		
9-0036	d within 72 hours after death with the Maryland ilene. r than "netural", or items 23a or 28a-f show I'te Medical Examilier i sust be indiffied at	ted by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 2 Natried 3 Widowed 4 Divorced Yea	E Decedent Ever in U.S. ed Forces?  Yes 2 No WWII ss. Give r or Dates:	10f. Zip Code  21215  Was Decedent of Hispanic O If Yes, specify Cuban, Mexics  1 ☐ Yes 2 ☐ No Specify  dent's Usual Occupation	y:	ry Yes or No- can, etc.)	14. Race - America Black, White, e Specify:	an Indian, etc. HITE		
Maryland 21215-0036		Completed	(Specify only highest grade complete of the co	ege (1-4or 5+) life.	e kind of work done during mo DO NOT use retired)  ESMAN			RINTING			
yland	be do do	To Be	SOLOMON			ANNA THE 2 MATTER (1	rist, Miggle, Mai	FEFFE	RBERG		
Mar	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Printer BARON / WIFE	·	ng Address (Street and Numb PARK HEIGHTS						
Baltimore,	0 0		20a. Method of Disposition 1 ¼ Burial 2 □ Cremation 3 □ Removal 1 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispe	osition (Name of matory or other place)	Dat	e 20d	LTIMORE, ME	vn, State		
Balt	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licensee	11/1 2	2. Name and Address of Faci	III PO	EVINSON	& BROS.,	INC.		
	Physician /Medical Examiner	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	that caused the death. Do not en e on each line.		s cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death		
P.O. Box 68760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	hysician/Medicai	ed		in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of deliver	y Day Year
	w requires tha been signed should be det	by	Part II. Other significant conditions contributin	g to death but not resulting in the u	inderlying cause given in Part	· I.		co use contribute to the	e cause of death?		
Vital Records,	The ate h page	Completed	Ceschae a	ullymie	,		24a. Was an autopsy performed	prior to condeath?	sy findings available ipletion of cause of		
of	ling Phye I. After this Juneral dii	ertification: To Be	2 Accident investigation	1 Inpatient 2 ER/Outpatie Date of Injury (Month, Day Year) 28b. Time o Injury	nt 3 DOA Other: 42	Jursing Home	Check only one)  5 ☐ Residence  d. Describe how	e 6 Other (Specify	)		
Division	in Bird	Certific	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	281	f. Location (Stree City or Town, S	st and Number or Rural State)	Route Number,		
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in	Medical (	(Check only 2 Medical Examiner: On	To the best of my knowledge, deal the basis of examination and/or in I manner stated.	th occurred at the time, date a evestigation, in my opinion, de	and place, and eath occurred	d due to the caus at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)		
	To the within 2 Complei	Me	29b. Signature and title of certifier	pws	29c. License number			Date signed (Month, D			
,	15		30. Name and address of pason who complete	· 7 6 2	Print) Reli	481	T QL	July 20 u felt	200 1		
• 5	Sta Registr		31. Date filed (Month, Day, Year)  JUL 2 5 200	32. Registrar's Signature	Scall )			Berl	in ore		

Cynt	hia Britton		State of Maryland / Department of Health a  1- For State Certificate of Death Registrar	and Mental Hy	giene Reg. No	o	······
Med	Physici dical Exam		1. Decedent's Name (First, Middle,Last)  Cynthia Britton		2. Date of Death Month Day July 22, 2007	Year	3. Time of Death 0600 hrs
No.				, or Location of Death		c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	Year If Under 24Hrs.	8. Date of Birth(MN	Foreign	place (State or
	Director		213-86-4118 1 M 2XF 43 Yrs. Months C	Days Hours Min.	Nov6,19	63 Cou	Maryland
	w any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 XNo
Y i	aryland 8a-f sho at once	Director	Md. Baltimore Dundalk  10e. Street and Number 10f. Zip Cod	Je	. 10g. C	itizen of What Count	
0	th the M 23a or 2 notified			222	-11	U.S.A	
	death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? ( Spe Jban, Mexican, Puerto F	ecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
	rs after o ural", o miner n	by F	3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occu		ork done 116h	Specify: Wh	ite
	6 172 hou nn "nati cal Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working			Tring of business/iii	
	5-003 ed within lygiene. other th	Comp	10th Waitress 17. Father's Name (First, Middle, Last)	18.Mother's Name (	(First, Middle, Maide	Restaura n surname)	nt
	MD 21215-0036 42 should be filed within 7 th and Mental Hygiene. a 27 is marked other than numatic event, the Medica	o Be	Joseph Stephen Jakubowski  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (S		Parker	City or Town State	Zin Code)
	MD 2 dought and I is a shown in 27 is rounatic		Shirley Jakubowski-mother   8005 Charl	lesmont R	d. Balt	imore, M	ld21222
	imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  "I firem 27 is marked other than "antural", or other traumatic event, the Medical Examiner."		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of crematory or other place)			Location - City or T	,
	at part part por ury	ŀ		ress of FaciliKacz	orowski	Funeral	. Home, PA
1	m		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyi	ndalk Ave			21222 Approximate Interval
3	/Medical raminer		failure. List only orfe cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Between Onset and Death
•			Sequentially list conditions,  b				
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	VE S			
	cuted ind transit	al Exa	events resulting in death) Last Due to (or as a consequence of):  d.		_		
	68760, certificate be executed ading physician and se as the burial - transit	Aedical	IF FEMALE:  AMENDED #23a.27.28a-f, perME.g870, 8/9/( 23c. If yes, outcome of pregnancy	07 TT	16	3d. Date of delivery	
	687 ertifica ding p e as th	ian/N	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnan			ay Year
	Box ne death of the atten ned for us	Physician/№	1 Yes 2 No 9 V Unknown g Unknown			· · · · · · · · · · · · · · · · · · ·	
	P.O. es that if igned by be detach	1 by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part 1.		o use contribute to t	he cause of death?  ably 4  Unknown
	Division of Vital Records, tal or Attending Physician: The law require at after cleath.  In State cleath.  In Diviner, After this certificate has been sifed in by the funeral director, page 2 should be	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	tal Rec cian: The la certificate h ector, page 2	ပ်	25. Was case referred to medical 26.Pl	lace of Death (Check or	performed 1 Yes 2		s 2 No
	Vital hysician this cer	To Be	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Othor		dence 6 Other:	= 7
	on of anding Plath.  The After refuneral		1 Natural 5 Pending (Month, Day, Year)	-i.i	28d. Describe how i	njury occurred	
	IVISION On Attenuate death Director:	Certification:	2 Accident Investigation   Fnd 7/21/2007   Unk   28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street	and Number or Rur	al Route Number, City	
	Hospi 24 hou Funer ely fil		4 Homicide determined (Specify) found at home  29a. Certifier (Check only (Che				Dundalk, MD
	To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.				
		2		cense number		i. Date signed <i>(Mon</i> lly 24, 2007	un, Day, rear)
	07		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn	Street, Baltimore	MD 21201		
		tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Oueet, Dalumore	5, NID 2 12U 1		
	Regis	trar	JUL 2 5 2007 Bour & Spark				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Penartment of West Wental Hygiene 23a PtI Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death COMY Day Physician Her ber 1803 PM 2007 /Medical 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita HOPEINS JOHNS Balti more 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F 214 56 3179 56 Director ,1951 FEB. MD. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director L Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 HOMESTEAD ST. 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1√ Yes 2 No IFYes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) USPOST OFFICE mailhandler 3 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROGER CORRY, SR. ARSONIA DEGraffenreid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORETHA CORRY / sister 1105 HOMESTEAD ST. BALTO, MD. 21218 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7, MAR. 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If eny injury or once. GARRISON FOREST VET.CEM. 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 21213 Approximate Interval Between Onset and Death 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hematoma Immediate Cause (Final Subdura Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER M. R. M. J. Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death ed by the a 5 Other (specify) 9 Unknown 9 Unknown s been signed by t ? should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X es 22(40 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. Accident investigation 02/28/2007 Unknown <sup>M</sup> 1 ☐ Yes 2 No Subject fell down stairs 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1105 **Homestead St., Balto., MD**  Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Res-000 March 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Athir Morad 600 North Wolfe Street Baltimore, Maryland 21287 Morad 31. Date filed (Month, Day, 32. Registrar's Signature State 20 Registrar

DHMH 17 Rev 1/2001

07-05577 Tabitha Curry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tha Curry		State of Maryland / Department of Health an  1- For State  Certificate of Death	d Mental Hygiene
Physicia Exami	an/	Registrar  Desertent's Name (First, Middle,Last)	2. Date of Death  Month Day Year July 20, 2007  3. Time of Death 1001 hrs
LAUIII		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital  4b. City, Town, or Baltimore	r Location of Death 4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Day	Foreign
		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	10d. Inside City Limits 1
ith the Maryland 23a or 28a-f show notified at once.	rector	MD Baltimore  10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
eath w	uneral Dir	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	lispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black; White, etc.
2 hours after de "natural", or Examiner m	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 N  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup	ation (Give kind of work done 16b. Kind of Business/Industry
5-0036 led within 72 l Hygiene. I other than "1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Sumame)
the 21215-0036 and 2 should be filed within 72 earth and Mental Hygiene fem 27 is marked other than traumatic event, the Medical	To Be C	William Curry	eet and Number or Rural Route Number, City or Town, State, Zip Code)
and 2 shou lealth and ? tem 27 is r traumatic		20a Method of Disposition 20b. Place of Disposition (Name of C	st Cake Dt. Annapolis MD 21403  cemetery, Date 20c. Location - City or Town, State
Baltimore permit Pages 1 a Department of H Important: If it	1	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	Made 7/25/07 Raltingre, MD
Balti Balti Departit Import		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyr	1 50 K 1d. Rolto MD 21212
ledica amine		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Alcohol, narcotic and cocaine into Due to (or as a consequence of):	Death
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
Ng a ig	Examine		
50, ke be executed by sician and burial - transit	ledical	X UNPENDED AMENDED #23a,27,28a-f, perME, G869, 7/26/	/07 TT 23d. Date of delivery
ords, P.O. Box 68760, aw requires that the death certificate be reasonable by the attending physici as been signed by the attending physici as the buri	/sician/Me	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	3 Ectopic pregnancy Month Day Year
P.O. Es that the canada and the cana	by Phy		se given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Vital Records, P.O. Be hysician: The law requires that the de this certificate has been signed by the statement areas 2 should have deeped of the control of	Completed		24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital R	Bo C	25. Was case referred to medical examiner? Hospital: Inputient 3 POA	lace of Death (Check only one)  Other; Nursing Home 5 Residence 6 Other:
ling P	inner		Injury at Work?  28d. Describe how injury occurred  Yes 2 X No  unk
Division of Vital   19	tulled in by the rune	2 Accident Investigation Investigation 3 Suicide 6 Could not be determined 4 Homicide (Specify) Townhouse/ rowhouse	
To the Hospital within 24 hours a To the Funeral	۳ (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opi	e date and place, and due to the cause(s) and manner as stated.
	2		cense number 29d. Date signed (Month, Day, Year)  July 21, 2007
of pend		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Bal	ltimore, MD 21201
Reg	Sta	te 31. Date filed (Month, Day, Year) 5 2007 32. Registrar's Signature	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	State of Mary		artment of H rtificate of L		-	giene Reg. No.		23650				
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Dav	Year	3. Time of Death				
1	/Medic		Virginia Zeno					July	15, 20	007	12:30 pм				
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		ר		nty of Death					
			6113 Red Haven		to a to be to to a	East New		1		cheste					
	Funeral Director		218-03-2659	Sex 7. Age (li 1 ☐ M 2 💢 F	91 Yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 04/18	71916	9. Birthp Coun	lace (State or Foreign try) MD				
	ryland		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				1	Od. Inside City Limits				
	ter deeth with the Marylan Iteme 23a or 28a-f ehow Instruct be mutified at	Director	MD Dorche	ster	East Ne	w Marke	t				1 Yes 2 No				
	ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen o		itry?				
	• 23e	ral	6113 Red Have			21631			U.S						
920	within 72 hours effer deeth with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be multiled at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 \( \subseteq Yes \) 2 \( \subseteq No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🅱 No		pecify Yes or No o Rican, etc.)	Spec	ace - Americ lack, White, cify: Wh					
5-0	72 hc	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occupa	ition	rkina	16b. Kind of	Business/Ind	dustry				
Maryland 21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired,	)		Unifo	rm Co	mpany				
Þ	otho	Bec	17. Father's Name (First, Middle, Last	)			18. Mother's Nar	ne (First, Middle,	, Maiden Sum	ame)					
<u>a</u>	should be nd Mental r marked c	ToE	Charles Blake	Lambie			Kather	ine E.	Schr	eiber					
lan,	and l		19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Numb	er, City or Tow	m, State, Zip	Code)				
_	alth 27		Howard F. Cog1	e, Jr./Son							MD 21631				
0	ges 1 ar t of Hea if item or othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Inditional from State		osition (Name of matory or other place		Date		n - City or To					
Ë	t. Partmen tant: njury		4 Donation 5 Other (Speci			idge Mem									
Baltimore,	permit. Pages 1 a Depertment of He Importent: if item eny injury or other		21. Signature of Funeral Service Lice	nsee		2. Name and Addres					-				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the							Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition Chromic Obstructive Fullmonon Visitas								Onset and Death				
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):												
П	LAGITITICI	-	Sequentially list conditions,	b. COWPLE		wort to	urare								
_	ted	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (onds a co	onsequence or):										
<i>)</i>	axecur and al-trar	Examiner	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):										
68760,	tificate be executed g physicien and as the burial-transit	calE		d											
89	tificat ig phy as th	ledical		u.											
O. Box	The law requires that the death certificate be executed to hes been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit		by Physician/M	by Physician/M	ysician/N	yslcian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year
s, P.O	res that tigned by				Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.			ontribute to th	e cause of death?		
ord	w requir been si should	ted						12	Yes 2□No	3 Prob	ably 4 Unknown				
Vital Records,	The law ste hes boage 2 st	Completed								prior to cor death?	psy findings available incletion of cause of 2K No				
ita	ician: The l certificete he rector, page	ВеС	25. Was case referred to medical examiner?				26. Place of Dea			1 103					
	G	ဥ	1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatier	nt 3□ DOA Othe	1. 4 Nursing H	lome Resi	dence 6 🗆 C	ther (Specifi	1)				
ion	g fe g	atlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Work	at ? ∕es 2 □No	28d. Describe	how injury occ	urred					
Division of	tal or Attendis s efter death. et Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, sti Specify)	reet, factory, office		28f. Location ( City or To	Street and Nui wn, State)	nber or Rura	l Route Number,				
	To the Hospital or Atter within 24 hours efter de To the Funeret Directo completely filled in by th	Medical C	29a. Certifier 1 Certifying Pt (Check only one)	hysicien: To the best of m miner: On the basis of ex and manner stated	amination and/or in	h occurred at the tim vestigation, in my op	e, date and place linion, death occu	, and due to the irred at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)				
	To th withir To th comp	Me	29b. Signature and title of certifier	11.		29c. License	number		29d. Date sig	ned (Month,	Day, Year)				
			> any fu	roun	10	D006	31800		07	16/1	2007				
	20		BRIC DY, WI	completed cause of death	MID.	503 By	n St. C	iombrid	ge, W	J 0	1613				
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's	Signature	ويجي									

Vinigia Z. Cogle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fb/8870 8-7-07 yt State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 23 Year Month **Physician** CARTER KRISUS 0401 2007 JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Déath Examiner Johns HOOKINS HOS If Under 1 Year Age (In yrs. last birthday) 5. Social Security Number & Sex Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🕱 F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Completed by Funeral Director more 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ 19a. Informant's Name/Relationship (Type. Print) (Laughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Place of Disposition (Name of Careton Control or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 30/200 4 ☐ Donafton 5 ☐ Other (Specify) Tellacory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatic Failure /Medical Due to (or as a consequence of): **Examiner** patocellular Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner nis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2KNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an this certificate has autopsy 1□ Yes 2 X No i or Attending Physician: after death. Director: After this certifica To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 CInpatient 2 ☐ ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL DOCTUR RES-000 23,2007

DHMH 17 Rev 1/2001

State

Registrar

TUAN TRAN, John 31. Date filed (Month, Day, Year)

JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BACTIMORE, MRYLMO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 2 5 2007

32. Registrar's Signature

Physicia /Medic		- State Registrar Amend 20c, pe  1. Decedent's Name (First, Middle, La  WALTER E. CLARY						2. Date of De. Month	Day	Year <b>2007</b>	3. Time of Death 6:55 A		
Examin	No.	4a. Facility Name (If not institution, giv HERITAGE CENTER	e street and numb	er)		4b. City, Town, or DUNDAL	.K			unty of Death	E		
Funeral Director		223-26-1382	Sex 7. ■ M 2 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		v. Year)	9. Birthp Court <b>V</b> A			
ilied at	Director	Usual Residence of Decedent  10a. State 10b. County  MD BALTII	ORE	10c. Cit	y, Town or Lo				10d. Inside City Limits  1				
or 26	Dire	10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?					
rei', or iteme 23a or 28a-f ehow Exeminet must be notified at	by Funeral	2714 LODGE FARM I  11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 1 Yes 2 If Yes, Give Year or Date	es? □No	'		219 ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK				
natu	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0·12)			16a. Deced (Give life.	tent's Usual Occup kind of work done of DO NOT use retired	during most of v i)	working		of Business/Ind			
Health and Mental Hygiene. tem 27 le marked other then other traumatic event, the Ma	To Be Co	17. Father's Name (First, Middle, Last ROY THOMAS CLARY	)		,JIL	WORKIN		Name (First, Middle,	Maiden Sui	mame)			
and M	-		Type, Print)		19b. Mailir	g Address (Street	and Number or				Code)		
o = =		1 Starial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  PATILLO CHCH CEM  06/25/07											
		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - try or own, cemetery, crematory or other place)											
Medical and the porial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. REC Due to (or PARP	as a consequence as a consequence	IA	RINAR)	ions of	Thoraco-	Abdomi	inal			
red by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		h 2 ∐Feta itattime of d	ıl death 3 ☐	Ectopic pregnancy	CERTIFICATION	PARONES A. / C.	23d	. Date of delive Month	ery Day Year		
sign d be	þ	Part II. Other significant conditions	contributing to deal	th but not res	ulting in the u	nderlying cause giv	en in Part I.		obacco use Yes 2 N		ne cause of death) pably 4 punkno		
ate has page 2	Completed							24a. Was auto perfo 1 Yes		4b. Were auto prior to co death? 1 ☐ Yes	psy findings availa mpletion of cause 2010		
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or /	eath Check only o					
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	atlon: To	27. Manner Death 1 tratural 5 Pending 2 Accident investigation	28a. Date of (Month,		28b. Time of Injury	28c. Injur	4 Mursin	g Home 5 Resi 28d. Describe			ý)		
within 24 hours after death  To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not to determined	289. Place 0	Injury - At h	ome, farm, str fy)	eet, factory, office			(Street and Number or Rural Route Number, wn, State)				
the Funer	Medical	(Check only 2 Medical Exa		is of examina		vestigation, in my o	pinion, death o	ace, and due to the courred at the time,	date and pla	ice, and due to	the cause(s)		
o Lo	2	29b. Signature and title of certifier	151.0	Wo d	11)	29c. Licens	e number	78	29d. Date s	igned (Month,	∪ay, Year) <b>7</b>		
		- Savinae i	- Ju		n 23a) (Type,		-//0		-/-	-			

#230 line C.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:54PM 10500 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Hospital Rosedale vare Date of Birth (Month, Day, 3 -28 -If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** Months Days Hours laryland Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ms 23a or 28a-f show 1 ☐ Yes 2 XNo Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Item 27 is marked other than "natural", or Items other traumatic event, the Medical Examiner mi Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White, etc. Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Completed by filed within 72 hours 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Callege (1-4or 5+) Elementary/Secondary (0-12) Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rith and Mental h Be Pages 1 and 2 should be shiel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip code) boro Rd. Rosedale MD Baltimore, ortant: If Item ? 20a. Method of Disposition 5 Burial 2 ☐ Cremation 3 Removal from State Department o Important: If any Injury or 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Dirator /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be execute burial-tran Due to (or as a consequence of): Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9☐Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 ☐ Yes 1□ Yes 2 No 2 □ No or Vital Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 07/19/2007 C. M. selli D36663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dr. Stuart W
31. Date filed (Month, Day, Year)

JUL 2

5

10

Registrar's Signature

9000 Franklin Square Drive Baltimore, MO. 21237

Amend It State 25 Mary land | Penart ment of beath | Hygiene 23aPtI | Certificate of Death | Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death て Pay **Physician** Davenport Martha 7:25 PM 2007 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Johns Hopkins Hospital
Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**) F Months Days Yrs. Director 242-42-1600 North Carolina Jul. 7, 1931 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford **Edgewood** 10e. Street and Number 10g. Citizen of What Country? 2002 Bayberry Road 21040 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3₺Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sewing Machine Operator Shoe Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James McGibbert Rawls Beulah Marie Coburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Vineyard Drive, Port Deposit, Maryland 21904

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State James Davenport / Son 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Harford Memorial Gdn 6-2-07 Aberdeen, Maryland Signature of Funeral Service Licensee McCamas Funeral Home, P.A. \$317 Cokesbury Road, Abingdon, Maryland 21009 Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebral Hemorrhage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Subdural Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL BY AMINE or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): ر کہا گیا ہے۔ Division or Vital Records, P.O. Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an this certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours area To the Funeral Director: Aft 2 Accident 1 ☐ Yes 2X No Probable fall Unknown Unknown<sup>M</sup> 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown Unknown To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00063682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltinore AD 21287 600 N. Wolfe Maffheir koen. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 12:55 PM MILDRED ENDERS JULY 2007 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A BAYVIEW MEDICAL CENTER JCHUS HOPKINS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 □ X 220-38-9965 Director 8,1918 Md Aug. Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🛂 No Dundalk Baltimore Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21222 45 Wise Ave. death Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after crent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Maryland 21215-0036 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Housewife 9 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Myrtel Miller Klingmeyer Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joppa Md. 21085 224 Beechwood Ave. Kenneth Enders son 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ite any injury or ot July 23 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory permit. Page Department Baltimore 2007 connelly Funeral Home Of Dundalk 2 Signature of Funeral Service Licenses 7110 Sollers Point rd. 21222 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death at 1. Enter the disease, or com-shock, or heart failure. List only of Im or diate Cause (Final Respiratory Physician Failure 30 minutes disease or condition resulting in death) Due to (or as a consequence of): /Medical Examine I hour ASpiration Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Obstruction and -trar Due to (or as a consequence of) attending physician a Records, P.O. Box 68760. months olon Cancer Physician/Medical IF FEMALE If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No certificate 2 1 TYes Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Japatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A death. investigation 2 Accident completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RE5-000 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE, BALTIMORE, MD BERGER M.D. 4940 JONATHAIN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 5 2007

82. Registrar's Signature

			1 - For State Registrar	State of	of Maryland / I		artment of H		•	giene Reg. No.	2007	1, 3	663		
	Dhusisi		1. Decedent's Name (First, Mide	de, Last)					2. Date of De Month	ath Day	Year	3. Time of	Death		
	Physici /Medio		Vytautas	Р.	Eringis				July 20			5:00	D <sup>M</sup>		
	Examir		4a. Facility Name (If not institution	on, give street and nu	imber)		4b. City, Town, or	Location of D	eath	4c. 0	County of Deat	n	-		
			Summitt Park N	lursing Ho	ne		Catonsv			Ba	ltimore	!			
	Funeral		5. Social Security Number	6. Sex 1⊠M 2□ F	7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hours	din. (Month, Da	y, Year)	Co	nplace (State o untry)	or Foreign		
	Director		213-30-1420 Usuel Residence of Decedent		76	Yrs.			Jan. 1	, 19:	31 Lit	huania			
	land		10a. State 10b. Count	у	10c. City, Tow	m or Lo	ocation					10d. Inside Ci	ity Limits		
	after death with the Maryland or items 23s or 28s-f show infrar must be notified at	to	Maryland Balt	imore	Catons	svi	lle					1 🗌 Yes	2 <b>N</b> 0		
	28a	by Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?					
	3e or	Ī	403 Allview Ct				21228		USA						
	death	era	11. Marital Status	12. Was Dec	edent Ever in U.S.	13.		spanic Origin	? (Specify Yes or No uerto Rican, etc.)		4. Race - Ame	- American Indian, , White, etc.			
9		교	1 ☐ Never Married 21 Ma	rned 1 ⊠ Yes	orces? 2□No ive Korea Dates:	1			uerto Rican, etc.)		Black, White				
8		þ	3 ☐ Widowed 4 ☐ Divorce	d If Yes, Gi Year or D	ve Korea		1 ☐ Yes 2 ☑ No	Specify:		3	Specify:	White			
5-0	72 hours "naturel", idicel Ere	Completed	15. Decede	int's Education est grade completed)	16a		dent's Usual Occupa kind of work done d		working	16b. Kin	d of Business/	ndustry			
21		id.	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use retired,	)	g						
2	led w lygier har ti	ဒီ	12	2	<i>E</i>	Arcl	itect				nitectu	al Fir	n		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than any Injury or other traumatic avent, the Magnee.	Be	17. Father's Name (First, Middle Peteras		ei na i a				Name (First, Middle,	, Maiden S					
ž	J Mer nark	5			ringis			Eliza		01	(Unkno				
Na	12 st h and 7 la r traur	. 11	19a. Informant's Name/Relationship (Type, Print)  Ona R. Eringis (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  403 Allview Ct., Catonsville, MD 21228  20a Method of Disposition												
	1 and Healt Healt Ther		Ona R. Eringis (Wife)  403 Allview Ct., Catonsville, MD 21228  20a. Method of Disposition  20b. Place of Disposition (Name of properties)  20c. Location - City or Town, State												
ર્	Hit in or o		tx☐Burial 2 ☐ Cremation		State cemete	ry, cre	matory or other place				•		. 1		
Baltimore,	it. Partmel rtmer rtant njury		<u>`</u>		Loudor								nd		
Ba	Depa Impo Impo Inny I		Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Loudon Park Cemetery 7/24/07  Baltimore, Maryland  22. Name and Address of Facility Loudon Park Funeral Home  3620 Wilkens Ave., Baltimore, MD 21229												
			23) Parti, Enter the disease, of	or complications that	caused the leath. Do			-			10 2122	Approximat			
	Physician /Medical Examiner	er	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, rrany, leading to immediate	more	Elle (	3			Interval Bet Onset and I						
8760,	icate be executed physician and s the burial-transit	ai Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	Due to (or as a consequence of):  Due to (or as a consequence of):										
87	physicate the	g		d								**			
.O. Box 6	death certit e ettending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live i	tcome of pregnancy birth 2 ☐ Fetal death nant at time of death lown		Ectopic pregnancy Other (specify)			23	3d. Date of deli Month		Year		
Division of Vital Records, P.	The law requires that the de- ste has been signed by the e- page 2 should be deteched f	þ	Part II. Other significant condit	ions contributing to d	eath but not resulting i	n the u	nderlying cause give	n in Part I.		obacco us Yes 2 🗆	e contribute to		leath? Jnknown		
00	w require s been si should I	Completed		11 1	, <del></del>				24a. Was	an	24b. Were au	topsy findings	available		
Re	he la	E		()						rmed?	death?	completion of c	ause of		
tal			25. Was case referred to medic	al				26 Place of	1 ☐ Yes th (Check only of	2000	1 ☐ Yes	2D No			
<u>&gt;</u>	ysici s cer direci	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2☐ER/O	utpatier	nt 3 DOA Othe	- 1	g Home 5 ☐ Resi		Other (Sne	ofu)			
0	Attending Physician: r death. sctor: After this certificaby the funeral director.	盲	27. Mann of Death	28a. Date	of Injury 28b.	Time o		172 Tarket 177 Tarket	28d. Describe			ar <b>y</b> )			
<u>0</u>	ath. r: Aft e fun	Certification:	1 X Natural 5 ☐ Pend 2 ☐ ccident inves	ing (Mon tigation	th, Day Year)	njury		? Yes 2 ∐No							
<u>×</u>	Atte octo by th	illici	3 ☐ Suicide 6 ☐ Could	mined 289. Place	of Injury - At home, fa	ırm, stı	eet, factory, office		28f. Location (		Number or Ru	ral Route Num	ber,		
ā	s atte	ert	4 [] Hornicide	build	ing, etc. (Specify)				City or Tox	vn, State)					
_ a & a & O								e, date and p	ace, and due to the	cause(s) a	ind manner as	stated.			
	ha H n 24 ha Fu	Medicai	(Check only 2 Medica	and man	lasis of examination an iner stated.	iol/or in	vestigation, in my op	inion, death o	occurred at the time,	date and p	place, and due	to the cause(s	)		
	To T	∑	29b. Signature and title of certifi	"H Sa	alw	N	29c. License	number 2	128	29d. Date	signed (Month	3 LEL	2007		
Y	04,		30. Name and address of erso	wio cor pleted cau	se of death (Item 23a)	(Туре,	Print) / CA	ct	TIP 0	U DI	O'	Ellica	MA		
1	U		FINDE	- SKK	MHON	H	5457	71	John,	2 4	the	210	242		
	Sta Registr		31. Date filed (Month, Day, Yea.  JUL 2	5 2007	registrar's Signature	Soft	market			-		•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 8 per fh, g878, 05/08/08/08/dbb Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician J -letcher 2007 ulianna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Hopkins If Under 24 Hrs. 8. Date of Birth Hours Min. 08/11/1943 Social Security Number Age (In yrs. last birthday) If Under 1 Year **Funeral** Months 2.19-40-7746 10 M 2 XF Days Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No BALTO Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21205 4820 Wright Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ▼Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ZOSNOW SKI ANNA ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave. BALTO Md. 21205 SHAWN heR WRIG 20 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 ☐Removal from State 7-28-07 BALTO. Md. 21224 OAKLAWN CEMETERY 22. Name and Address of Yacilty
Wes ley Chavi's SV. FUNERAL HOME
2007 FASTERN AVE. BALTO. Moda 21. Signature of Funeral Service Licensee BALTO MAZIZZI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear hallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Days Subarachnoid Hemorrhage **Physician** /Medical Due to (or as a consequence of) Examiner erebrovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2MNo Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2' Accident the 6 Could not be determined To the Hospital or Atte within 24 hours after des To the Funeral Directo completely filled in by th 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Wolfe St.

N.

Baltimore,

600

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lonathan

31. Date filed (Month, Day, Year)

07-05574 Greg Foley

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar		C	ertifica	te of De	ath		R	eg. No.	21 5200
Physicia Medical Examin	n/	1. Decedent's Name (First, Midd Gregg	lle,Last) <b>Gregory</b>	Paul Fo	oley	Foley			2. Date of Dea Month July 20, 2	Dav Year	3. Time of Death 0812 hrs
9		4a. Facility Name (if not institution Peninsula Regional M		nber)			ty, Town, or L lisbury	ocation of De		4c. County of De Wicomico	ath
Funeral Director		5. Social Security Number 190–56–7624	6. Sex 1 X M 2 F	7. Age (in yrs	. last birth		Inder 1 Year onths Days	If Under 24 Hours	Min		Birthplace (State or eign Country) Pa.
any	F	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town o	or Location					10d. Inside City Limits
rland -f show once,	ē	Pa. Leba	non		Leb	anon	·: 0 :				1 Yes 2 No
the Mary 3a or 28a	Director	10e. Street and Number 609 Alleghan	y Street			101.	Zip Code 17018		1	0g. Citizen of What C	ountry?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 XNever Married 2 N	1 Yes			If Yes, sp	ecify Cuban,	Mexican, Pu	( Specify Yes or No erto Rican, etc.)	White, etc	_
urs after tural",	희	Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grade		) 16a. E	ecedent's Us		on (Give kind	of work done	Specify: WI	nite ss/Industry
)36 thin 72 horner re. than "na	Completed	Elementary/Secondary (0-12) G.E.D.	College (1-	4 or 5+)	- °	luring most of	working life.  urctio		retired)	Various	
21215-0036 unld be filed within 7 Mental Hygiene. marked other than it event, the Medica		17. Father's Name (First, Middle Paul	e, Last)		1		1	8.Mother's N	ame (First, Middle,	Maiden Surname)	-
212 ould be d Menta s marke ic even	To Be	19a. Informant's Name/Relation	Ship (Type, Print )	-		Foley  Mailing Add	ress (Street		inia or Rural Route Nur	M. Ca	ain ate, Zip Code)
MD and 2 sho salth and 2 sho sm 27 is raumat		Virinia M. Ho 20a. Method of Disposition	stetter	Moth		111 N			Apt. 1, C	Camp Hill,	Pa. 17011
Baltimore, MD oemit. Pages I and 2 sho Department of Health and Inportant: If item 27 is injury or other traumat		1 X Burial 2 Cremation 4 Donation 5 Other S			cremato	nd Gre	ace)	,	'-25-07	Camp Hi	
Balti permit. Departr Import injury		21. Signature of Kuneral Service					and Address		March F	.H. East imore, Md.	21202
Physician Wedical	$\exists$	23a. Part I. Enter the disease, of failure. List only one cause		used the dea	ath. Do no	t enter the mo	ode of dying, s	such as cardi	ac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
** Aaminer		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a			Head		fi.			Death
	-e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	e of):		-		_		
=	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
My sian and sial - tra	Medical E	UNPENDED	d. X AMENDED #1, per	M Fo870	2 10/	15/07 TI	7				
3760, ificate by g physic	n/Mec	IF FEMALE: 23b. Was decedent pregnant in	1 23c. If yes, c	utcome of pi	regnancy			Ectopic pre	egnancy	23d. Date of deli	very Day Year
Box 687 e death certifing the attending led for use as t	sicia	past 12 months?  1 Yes 2 No 9 Ur	4 Pregna	ant at time of	death 5					, washar	20,
ires that the disease signed by the	d by Phy	Part II. Other significant cond	itions contributing to	death but no	ot resulting	in the under	lying cause gi	ven in Part I.			to the cause of death?  Probably 4 Unknown
cords law requ has been	Completed										
Vital Reo ysician: The his certificate director, page	Be Co	25. Was case referred to medic examiner?							eck only one)	2 10 1	100 2 110
f Vit	욘	1 Ves 2 No  27. Manner of Death	Hospital: 1 In 28a. Date			utpatient 3		Other <sub>4</sub> Nork?	ursing Home 5	Residence 6 0	ther:
sion of Atending Phydeath.  ctor: After the funeral	ertification:	1 Natural 5 Per	nding Jul 19, 2	Day Year) 007	2256	6 hrs	1_Y	es 2 🗸 No	Subject sho	ot self	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Certific	4 Homicide det	lid not be	of Injury - A Local St		rm, street, fa	ctory, office bu	uilding, etc.		(Street and Number or State) oga Street, Salisbur	Rural Route Number, City y, Md.
To the Hos within 24 h To the Fun	Medical (		Physician: To the best aminer: On the basis of and manner st	f examinatio							
F X F S	Me	29b. Signature and title of certif		ated.			29c. License			29d. Date signed (	Month, Day, Year)
		30. Name and address of person	n who completed caus	e of death (I	tem 23a)		0.C.N	/I.C.		July 22, 2007	
3		Ana Rubio MD. As	sistant Medical E	xaminer	111 F	Penn Stree	et, Baltimo	re, MD 21	201		
St Regist	ate rar	31. Date filed (Month) Day, Year	5 2007 32.	gistrar's Sigr	nature	Charle	5				

DHMH 17 Rev 1/2001

ORIGINAL

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Mission of Vital necolds, F.O. Doz ool oo,		המווווסוב, ואומו אומוות בובוי
or Attending Physician: The law requires that the death certificate be executed after death.	Phy /M Exa	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hydiene.
<b>Director:</b> After this certificate has been signed by the attending physician and in by the funeral director, nade 2 should be detached for use as the hintel-transit.	sici edio mir	important: If item 27 is marked other than "r

		For State	State of	of Maryland	•	rtment of H		Mental H	ygiene					
		Registrar			Cer	tificate of l	Death		Reg. No.			1		
Physicia	an	Decedent's Name (First, Middle	, Last)					2. Date of D Month	Day	/ Year	3. Time of	Death		
/Medic		Anna Fraun						July		007	8:30	P M		
Examin	ner	4a. Facility Name (If not institution				4b. City, Town, or		th		County of Death				
		Ellicott City  5. Social Security Number	Health ar	nd Rehab 7. Age (In yrs. Is	ast hirthday)	Ellicot If Under 1 Year		8. Date of E		oward	place (State o	- Familian		
Funeral Director		216-32-7007	1 M 2 M F	9.		Months Days	Hours Min	(Month, L	15, 1	912 Roma	ntry)	r roreign		
_		Usual Residence of Decedent						1106.	1, 1	NOINA	шта			
yland		10a. State 10b. County		10c. City	, Town or Loc	cation					I0d. Inside Ci	ty Limits		
a-f s	ctor	Maryland Howa	rd		Ellico	tt City					1 ∐Yes	2 🔀 No		
th th	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	ntry?			
23a ust b	ral	8925 Old Fred	erick Roa	ad		21043	3			USA				
tems	Funeral	11. Marital Status	Armed F	edent Ever in U.S orces?	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Pue	Specify Yes or Norto Rican, etc.)	No-	<ol> <li>Race - Americ Black, White,</li> </ol>				
or i	by F	1 ☐ Never Married 2 ☐ Marri 3 🖾 Widowed 4 ☐ Divorced	I If Yes, G	2 ☑ No ive	1	☐Yes 2X No	Specify:			Specify: Whi				
hour tural	pe pe	15. Decedent	Year or D	Dates:	16a Docod	ent's Usual Occupa	ation		10h K					
in 72 "na" ra ledic	Completed	(Specify only highes	t grade completed)		(Give I	kind of work done of NOT use retired	during most of wo	orking	100. KI	пd of Business/In	dustry			
with iene. thar	E O	Elementary/Secondary (0-12)	College (	1-4or 5+)		emaker	,			Oran II ama				
Hyg Hyg other ent, 1	BeC	17. Father's Name (First, Middle, I	Last)		110111	emaker	18. Mother's Na	me (First, Midd	le, Maiden	Own Home Surname)				
lid be fenta ked kc ev	To B	Michael Ha	rter				18. Mother's Name (First, Middle, Maiden Surname)  Laura Roth							
shound N		19a. Informant's Name/Relationsh	nip (Type. Print)		Laura Roth  Jumber or Rural Route Number, City or Town, State, Zip Code)									
and 2 alth a 27 is er tra		Anna Appell - Daughter 8925 Old Frederick Road; Ellicott City, MD 21043												
of He		Anna Appell - Daughter    20a. Method of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20c. Location - City or Town, State   20c. L												
Page nent on		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S <sub>I</sub>		State	-	herd Cem	i i	26-2007	F114	icott Ci	tu Mos	rulan.		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Foheral Service I	Licensee	1/	22	Name and Addres	s of Facility St	erling-	Ashto	n-Schwal	o-Witzl	ke		
De la la la la la la la la la la la la la		21. Signature of Foheral Service Licepsee 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228												
		23a. F. 111. Enter the disease, or shock, or heart failure. List	mplications that	caused the death							Approximate Interval Bet	e		
Physician		Immediate Cause (Final disease or condition			ic Si	dotac	Duly	mo@m	1)11	Reare	Onset and I	Death		
/Medical		resulting in death)	Due to	(or as a consequ	ence of):	7	pour	110110.19	0					
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p #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	ence of):									
ecute and -trans	Examine	that initiated events resulting in death) Last	C	<b>/</b>										
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icate be executed physician and s the burial-transit	dical		d											
ding se as	Me	IF FEMALE:	23c If yes ou	itcome pf pregnai	nev									
leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fetal	death 3 🗆	Ectopic pregnancy Other (specify)			1/2	23d. Date of deliv Month	,	Year		
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unkr		saur 5_	Other (specify)			.					
w requires that the d been signed by the should be detached		Part II. Other significant conditio	ns contributing to c	leath but not resu	Iting in the un	derlying cause give	en in Part I.	23e. Dio	d tobacco u	ise contribute to t	he cause of d	leath?		
uires sign d be	d by							10	Yes 2	□ No 3 □ Prol	oably 4 🖟	Onknown		
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The lav	d L							aut	topsy rformed2	24b. Were auto prior to co death?	mpletion of c			
sician; Th certificate rector, pag		25. Was case referred to medical						1□ Yes	2 No	1 ☐ Yes	2 No			
Physician; this certifical	Be c	examiner?	Hospital:	Inpatient 2 1	EB/Outnoties	Othe	26. Place of De							
Phy er this eral d	1: To	27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	28c. Injun		Home 5 ☐ Re 28d. Describe		6 ☐Other (Special of Control of	<i>(y)</i>			
th. :: Afte	tior	1 Natural 5 Pending 2 Accident investig	d .	nth, Day Year)	Injury		k? Yes 2∐No			,				
Atter r dea ector by the	fica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200. Place	e of injury - At ho	me, farm, stre	et, factory, office				d Number or Run	al Route Num	ıber,		
al or s afte	Certification:	4   Hornicide	build	ling, etc. (Specify	")			City or T	own, State	)				
ospit hours uners ly fille		29a. Certifier Certifying	g Physician: To the	e best of my know	wledge, death	occurred at the tin	ne, date and plac	e, and due to th	e cause(s)	and manner as	tated.			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	One)	Examiner: On the land man	nner stated.										
Mit P	Σ	29b. Signature and title of certifier				29c. License	e number		29d. Dat	te signed (Month,	Day, Year)			
05		9	= Claud			D3	0641		J	uly 24	200	T		
5		30. Name and address of person v	who completed cau	se of death (Item	23a) (Type, I	Print) ///	ch Dage	1 0 1	h	a Mul	1.10:	221		
/		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  Tuly 24 200 7  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ramesh Sabapalku 201-109 Back Rived Weck Raed Raltimore Wayland 7/22/1  31. Date filed (Month, Day, Year)  32 Registrar's Signature												
Sta Registr	ite rar	JUL 2 5	2007 1	registrar s Signat	Sen.	(30)								
riogisti	71	20010	John	المال المالايل	See Free	360								

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	State of Maryland / Department of Heal  Certificate of Deal	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Abraham Flatau	2. Dete of Deeth Month Dey Year 7 21 2007 7:15 At
Examiner	The Facility North (Il not listitution, give of our of the listing)	ty, Town, or Locetion of Death  4c. County of Deeth  HAFFORD
Funeral Director	5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If U	Inder 24 Hrs.  8. Date of Birth (Month, Day, Yeer) 9/06/1936  9. Birthplace (State or Foreign Country)
the Maryland 28s-f show notified at	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location  MD HarFord Bel Air	10d. Inside City Limits 127 es 2 No
with the 3a or 28 If be not	300 W. Ring Factory Rd #211 21014	10g. Citizen of What Country?  U, S, A.
11215-0020 within 72 hours efter death with the Marylend ene. than 'natural', or items 23a or 28a-f show he Medical Examiner must be notified at ompleted by Funeral Director	11. Maritel Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
ind 21215-0020 be filed within 72 hours of lel Hygiene. d other than *natural*, or event, the Medical Exam Be Completed by I	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Engineer	g most of working  16b. Kind of Business/Industry  Governmen F
yland 21 build be filed with Mentel Hygien arked other the attic event, the	17. Fether's Name (First, Middle, Lest)  Isadore Flatau  18.	Mother's Name (First, Middle, Maiden Sumame)  Mollie Dunsky
Mar nd 2 shoulth end 27 is m	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and No. 2004 Stock)	Number of Rurel Route Number, City of Town, State, Zip Code) frn Rd. Joppa MD 21085
Baltimore, semir. Peges 1 er separtment of Hea mportant: if Item; inty injury or other ance.	20a. Method of Disposition  1 Burial 2 Cremation 3 (Removal from State 4 Donetion 5 Other (Specify)	Date Params New Jers ex
Balti permit. I Departm Importar any inju pnce.	21. Signature of Funeral Service Licensee 22. Name and Address of 8900 REISTER	
<b>3</b>	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.	ich as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition a. Coronpry Pulmonary	ACTUST MINUTS
CARLES AND A	Due to (or as a consequence of):	y disense years
68760, fricete be executed physician and ss the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as e consequence of):	
	resulting in death) Last	
P.O. nat the de by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 23b. Did tobacco use contribute to the cause of death
Division of Vital Records, or Attending Physician: The taw requires that deter death.  Director: After this certificate has been signe in by the funeral director, page 2 should be ertification: To Be Completed by	PANUINSON'S  PEN PHISL VASC TISEAN	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
Il Rec		1 Yes 2 No 1 Yes 2 No
Vita		i. Place of Death (Check only one)  ASSISEM  4□ Nursing Home 5□ Residence (Other (Specify) CAPU
Division of Vital Re within 24 housital or attended Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury at Work?	28d. Describe how injury occurred
Division After after dea after dea Director din by the Certifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
Division or to the Hospital or Attending Ph Within 24 hours after develor: After thi completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, do not not not not not not not not not no	date and place, and due to the cause(s) and manner as stated. on, death occurred at the time, date and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier 29c. License number 29c. Lic	889 July 21, 2007
100	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)  LINED SPOND MD LIS W. MSCPH.  31. Date filed (Month, Dey, Year)  32. Registrar's Signeture  JUL 2 5 2007	sil Bel Ain MD 21014
State Registrar	31. Date filed (Month, Dey, Year)  32. Registrar's Signeture	

### Places Type or Print in Plack Indelible Ink. Engure All Copies Are I

		For State Registrar	State of Mary		ertificate of I		Re	g. No.	07 2087	
Physicia /Medica	-	1. Decedent's Name (First, Middle, LESTHER	LERNER		FRIEDMA		2. Date of Death Month JULY	20 2	3. Time of Death 9007 5:32P M	
Examine		4a. Facility Name (If not institution, go	ED LIVING-PI		PIKESVI	LLE  If Under 24 Hrs.	C Data of Bidh	4c. County	TIMORE	
Funeral Director		5. Social Security Number 6. 212-05-8795 Usual Residence of Decedent	4 Tay of Yr	90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 01/18/1	917	9. Birthplace (State or Foreign Country) MD	
a-f show ified at	ctor	10a. State 10b. County  MD BALTI		c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 🔏 No	
ust be not	ral Director	10e. Street and Number 6 GREEN HEATHER				1208			What Country?  USA	
o "le	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1  Yes, Give Year or Dates:	r in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc. v: WHITE	
و ع	e Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work t)		Kind of Business/Industry  MILLINERY		
d out	To Be Co	17. Father's Name ( <i>First, Middle, Las</i>		BOOKKEEPER MILL  18. Mother's Name (First, Middle, Maiden Surna  LERNER ROSE						
s ma s ma numa	F	19a. Informant's Name/Relationship BARRY FRIEDMAN /	, ,,	19b. Mai	ling Address (Street	and Number or Rur				
Department of Health Important: If Item 27 i any Injury or other tra		20a. Method of Disposition  1  Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	□Removal from State	BETH <sup>et</sup> EX ci PARK		op 07/2	2/2007 DL LEVINS	RANDAL ON & B	LSTOWN, MD ROS., INC. LLE, MD 21208	
nysician Medical xaminer pruial-trausit	Exa	23a. Part1. Enter the disease, or conshock, or heart failure. List only manediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	ensequence of):					Approximate Interval Between Onset and Death	
attending phys	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p  1 ☐ Live birth 2 ☐  4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnancy □ Other (specify)				te of delivery onth Day Year	
been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause give	en in Part I.			tribute to the cause of death?  3 □ Probably 4 □Unknowr	
	Completed						24a. Was ar autops perform 1 Yes 2	neda	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
is certifi director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigati	28a. Date of Injury (Month, Day Ye	2 ER/Outpati	of 28c. Injur	er: 4 Nursing Ho	h <i>(Check only one</i> ome 5 ☐ Reside 28d. Describe ho	nce 6 On	Assita ner (Specify) Living red	
hin 24 hours after death.  the Funeral Director: After th mpletely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e Place of injury				28f. Location (St. City or Town		per or Rural Route Number,	
e Funeral te Funeral tetely filled	Medical C		Physician: To the best of maminer: On the basis of exa	amination and/or						

Division or Vital Records, P.O. Box 68760, To the Hospital or Ai within 24 hours after or To the Funeral Direct completely filled in by

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar's Signature 31. Date filed (Month, Day, Year) 5

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

3. Time of Death 14:501 2007 4c. County of Death BALTIMORE IPZOH TA N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday)
SEVENTY OVS.E 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days 1 ☐ M 2 🗹 F Months MARKEH 29 1936 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Glen Burnie 1 Yes 2 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1470 Gordon Drive 21061 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No þ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other treasment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Schlicting Alice Cookson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candy Smallwood / Daughter Glen Burnie, Maryland 21061 1470 Gordon Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 7/26/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Ineral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Solor the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide t 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. 5 HOUSE OFFECER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S HANOVER STR BALTIMORE, MD, 21225 32. Registrar's Signature State

Marie & Joseph

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

			For State		State o	f Maryl		artment of F rtificate of		Mental Hy				~ 9
		-	Registrar     Decedent's Name	ne (First, Middle	e. Last)			Timodic or		2. Date of D	Reg. N	2.0.1	3. Time of E	
ı	Physici		JESSA	to (r not, magn	, 2007		G	OLDBERG		Month JUL	D	ay Year		
	/Medio			If not institution	n, give street and nu	mber)			r Location of Deat			c. County of Deat		
			Saint	Josep	h Medic	al Ce	enter		Tows				imore	
	Funeral Director		5. Social Security N 212-28-		6. Sex 1 □ M 2 🛣 F	7. Age (In	yrs. last birthday, 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth Pay, Yea /193	9. Birt Co	nplace (State or untry) MD	Foreign
	p »		Usual Residence o	of Decedent		100	. City, Town or Lo	neation					10d. Inside City	v Limits
	aryla shov	'n		,	ETMORE	100							1 □Yes	
	the M	ect	MD 10e. Street and Nu		TIMORE		BALTIMO	10f. Zip Code			10a C	Citizen of What Co	untry?	
	with a or	ä							208		log. c	USA	unity.	
	eath	era	7 PACERS	LANE	12. Was Dec	edent Ever i	in U.S. 13.			Specify Yes or N	lo-	14. Race - Ame	rican Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 Never Mar		Armed Fo	orces? 2 <b>X</b> No ive		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	an, Mexican, Puèr Specify:	to Rićan, etc.)		Black, White Specify: Wh	e, etc. IITE	
5-0	72 ho natu	etec	(Spe	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wo	rking	16b.	Kind of Business/ LTIMORE	Industry COLINTY	
2	ithin ne.	Completed	Elementary/Sec		College (					5		DUCATION	COUNTY	
	filed w Hygiei other th	ខិ	12	/ First Middle	1 ant)			SECRETARY	18. Mother's Na	ma (Eiret Middl				
anc	htal H	Be	17. Father's Name	(First, Middle,	Lasij					ne (First, Middle	e, ivialue	en Sumame)		
Ž	should be in a Mental in arked o	မှ	HERMAN 19a. Informant's N	Jame/Relations	hin (Type Print)		KALLI 19b Mail		SARA Sumber or B	ural Bouta Num	her City	v or Town State 2	WISE (in Code)	
Maryland	d 2 s Ith an 27 is u		HOWARD G			מע		CERS LANE	ural Route Number, City or Town, State, Zip Code) ORE, MD 21208					
	s 1 and F Health Item 27 other tr		20a. Method of Dis		u / 11000/11		b. Place of Disp		i	Date		Location - City or	Town, State	
Baftimore,	t. Pages tment of b tant: If ite		4 □Donation	5 Other (S		State	BALTIMO	RE HEBRÉW	07/2			STERSTON		
Bai	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee  MH (Specify)  BALTIMURE HEBREW 107/23/2007 REISTERSTOW  22. Name and Address of Facility SOL LEVINSON & BROS 8900 REISTERSTOWN ROAD - PIKESVILLE											
	- 45		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
-	Physician		Immediate Cause disease or condition	on	a. INT	ERNAL	BLEED	ING					Onset and D	eatn
	/Medical Examiner		resulting in death)			•	nsequence of):							
6	LXammer	_	Sequentially list co	onditions	D			PSEUDO	ANEURYS	M				
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	icate be executed physician and s the burial-transit	Examiner	that initiated event resulting in death)	ts Last			IC PSE	UDOCYST						
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Δ.	that ted by	H.	Part II. Other sign	ificant conditi	ons contributing to c	leath but not	t resulting in the i	ınderlying cause giv	en in Part I.	23e. Did	l tobacc	o use contribute to	the cause of de	eath?
rds	quires n sign lld be	d b	_ACUTE R	RENAL E	AILURE					1 🗆	] Yes	2 <b>∑</b> No 3 □ Pi	obably 4 □U	Inknown
Records,	> 9 50	Completed by								24a. Wa	ıs an	24b. Were au	itopsy findings a	available
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tal	an: tificat tor, p	Be C	25. Was case refe	erred to medica	J				26. Place of De			NO IL Tes	2   110	
or Vital	Physician: this certificated director,	To B	examiner? 1 ∐ Yes 2 <b>X</b>	] No	Hospital: 1 🗶	Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	ner: 4 \(\sum \) Nursing I	Home 5 ☐ Re	sidence	6 □Other (Spe	cify)	
0	ng Ph ter th neral		27. Manner of Dea		28a. Date	of Injury oth, Day Yea	28b. Time (	of 28c. Inju	ry at rk?	28d. Describe	e how in	jury occurred		
iõ	Attending r death. ector: After by the fune	atio	1X Natural 2 ☐ Accident	5 Pendir investi	gation		,		Yes 2 □ No					
Division	al or Att after de I Directe d in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	ained 286. Place	e of injury ling, etc. <i>(S</i>	At home, farm, stoecify)	reet, factory, office		28f. Location City or T	(Street own, St	and Number or Rate)	ural Route Numb	ber,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one)		ng Physician: To th Examiner: On the i									)
	To the within To the Comp	Me	29b. Signature and	d title of certifie	1/2			29c. Licens	se number 46356		29d. [	Date signed (Mont	h, Day, Year) 2007	
,	1		30. Name and adg	ress of persor	who completed cau	se of death	(Item 23a) (Type		y too; pasel book book			1		
Ĺ	6 1		_KHOSRO					LER DRI	VE. TOW	ISON. M	18RY	LAND 2	1204	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-1 per me,2869,07/20/07dhb

Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 08 30 M 2007 July 80 Harris /Medical Cecile 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie
If Under 1 Year | If Under 24 Hrs. Anne Arundel Baltimore Washington Med Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min Hours 1 □ M 2 ☑ F 1910 TNDirector 16 088-18-4235 96 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at X□Yes 2□No Director NA Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 3604 Edgewood Road Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important; if Item 27 is marked other that any injury or other traumaria. Home Housewife 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lida M. Goodall <u>Benjamin F. Carr II</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 3604 Edgewood Road, Baltimore, Md Dorothy Phillips-Daughter
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 7/10/2007 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pa.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Immediate Cause (Final dise se or condition real ting in death) amst hysician SMAGML /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequinos of) Examine Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a lid be detached for 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 N 1 Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 ☐ Yes 2X No Multiple Falls Unknown M Hospital or Attendi thours after death. Funeral Director: A 2 Accident Unknown 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown Unknown within 24 hours a To the Funeral I Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D63726 JAT1820+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 MAJERODURMI KUMMI 31. Date filed (Month, Day, Year) JUL 2 0 2007 🚀 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. AMEND ITEM#20a perFH G869 7/25/07 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 300 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hop Kins mone HOSpita If Under 1 Year 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) rs. last birthday ial Security Number **Funeral** Days Min. 1 M 2□F 7-52-2869 -18-46 Director Irainia Usual Residence of Decedent 10c. City, Town or Location . Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heath and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Funeral Director MDltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2121 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) ondary (0-12) College (1-4or 5+) IORICE permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 Is marked other to any Injury or other traumatic event, th once. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip od 19a. Informant's Name/Relationship (Type. Print) liFe 20a. Method of Disposition Eurial 2 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 24/07 4 ☐ Donation 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of the shock, or heart failure. List only one cause on each line. g. such as cardiac or respiratory arrest. Immediate Cause (Final Hemonnhage Physician LATRACRANIAL 21 Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner M controlled if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed to should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 July 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berkeley, 600 N. Wolfe St., Baltimore, MD 21287 Jemiter' 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2007 Registrar

			1_ State	partment of Health and M <i>ertificate of Death</i>	, ,						
			Registrar  1. Decedent's Name (First, Middle, Last)	- Death	2. Date of Death	No.	3. Time of Death				
В	Physici				Month	Day Year	M				
	/Medic		John William Hart  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 23,	4c. County of Death	10:00 A				
7	LAdiiii	CI	Maryland Masonic Home	Cockeysville		Baltimor	9				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birth	lace (State or Foreign				
Г	Director		218-03-8456   1 <sup>™</sup> 2□ F   94 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 11/3/12	Mary	land				
	pu ,		Usual Residence of Decedent								
	anyla show d at	-	10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits				
	he M.	Director		keysville			1 ☐ Yes 2 No				
	vith the		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?				
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	300 International Circle  11. Marital Status 12. Was Decedent Ever in U.S. 1	21030		USA	an Indian				
	item item	Š	11. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. Never Married 2 Married  1. Ways 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,					
36	Ir, or	by F	3. Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	White				
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9	al Hy lothe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Mai						
Maryland	uld b Menta Irked	To E	John Beaurguard Hart	Ida Margaret Mueller							
an	2 sho and l is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	illing Address (Street and Number or Run	al Route Number, Ci	Route Number, City or Town, State, Zip Code					
≥ `	and sealth			O Hess Road Fallst		aryland 21047					
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Dis Ball Ball Ball Ball Ball Ball Ball Ball	position (Name of rematomy of other place)  Tellia LOTY	Date 200	c. Location - City or To	own, State				
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Bail	ermit epan npor ny In nce.		21. Signature of Funeral Service Licens	22. Name and Address of Facility Lou	don Park	Funeral Ho	ome				
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			23a. Part1. Enter the disease, or compliments that caused the death. Do not a shock, or heart failure. List only one cause on each line.		or respiratory arrest,		Approximate Interval Between Onset and Death				
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	ompl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)				
			P.+ Telestins	D21111		7/241,0					
	1341	ł	3Q. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		-///-/					
	10		Robert T. Liberto 3508 Bank Street Balto. Md. 21224								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JOHN LEONARD HCLLAND JA. 10:04 A.M JULY 21, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist CENTER TOWSON BAltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sev 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1**X** M 2□ F 220-82-5179 25, ALZ Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at BAltimore 1 Yes 2 No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U-S.A 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHIL5 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Gray MANOR GARAGE Mechanic 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be SR. Bett LEONARD HOLLAND ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If Item 27 is m any injury or other traum EAST - Mother VENYC 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State BAlto. CrenAt Loudon PACK July 25, 2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Charles 5. Zani 21. Signature Frineral Service Licensee Highland 21224 420 23a. Part1. Enter the diseate, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dans /Medical Due to (or as a consequence of): Examiner baCHEMAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 Who Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 The (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛌 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signa are and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AARON J. CHANNES MO 670) N: CHANGEST TOWSON MD 21204

32. gistrar's Signature

58303

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** ELIJAH. JA40BS 07 3: 10 A.M. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE RALTIMORECIT SAMARITAN HOSPITAL GOOD 8. Date of Birth (Month, Day, Y APR. 18, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year) **Funeral** Months Days Hours Min. 1X M 2 ☐ F 47 1960 Director 220-72-2978 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b County Department of Health and Mental Hygiene. Industrial, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Directo BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 USA FRANKFORD AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: ģ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) AOUATIC CENTER 12TH FISH CARETAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY BUIE ၉ ELIJAH JACOBS, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 N. CURLEY ST., BALTIMORE, MD 21205 NORMA JACOBS/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5500 O DONNELL ST. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 07/18/2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) BAYVIEW 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Fuperal Service Licenses 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part. Efter the disease, or omplications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Renal disease Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Year page 2 should be detached for in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No this certificate 1∐ Yes Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DDA Certification: To 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural
2 Accident 5 ☐ Pending investigation Injury 1 Tyes 2 □ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital. Good Sharma Sanari tan 32. Registrar's Signature 31. Date filed (Month State

Registrar

			For State Registrar	State of M	arylan	_	artment rtificate			nd Me	-	giene Reg. No.	00	1 :	[337]
	Physic		1. Decedent's Name (First, Middle, La	Joh	hs	00				2	2. Date of De	ath Day	20°	3.	Time of Death
	Examir	ner	4a. Faqility Name (If not institution, giv	al Clr	ALV		4b. Cft), T	Uti	Location of	Ny	MD		ounty of De	N/A	
-	Funeral Director	,	5. Social Security Number 2 16 2 12 4 1 6. S Usual Residence of Decedent	1 M 2 Q F	ge (In yrs)	Ast birthday) Yrs.		Days	Hours	Min.	B. Date of Birl	7993	0 9.8	irthplace Country) Mai	(State or Foreign ryland
	e Maryland a-f show ified at	ctor	10a. State 10b. County  Maryland	N/A	10c. City	y, Town or Lo	cation	В	altimore	е					nside City Limits
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 713 Wildwood Parkwa	ау			10f. Zip 0	Code	212	229		10g. Citize		Country? J.S.A.	
936	urs after dea al", or items Examiner mu	þ	11. Marital Status  1 ☐ NY€ver Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates;			Was Decede f Yes, speci I ☐ Yes 2		panic Orig n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No can, etc.)		. Race - An Black, Wh pecify:		
Maryland 21215-0036	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	5+)	- (Give	lent's Usual kind of work OO NOT use	done du retired)	tion uring most	of working	,	16b. Kind of Business/Industry  Hospital			
land 2	nd be filed fental Hygi rked other ic event, t	To Be Co	17. Father's Name (First, Middle, Last	) L. Johnson		Å			18. Mother	's Name (i		t, Middle, Maiden Surname) Sadie Johnson			
Mary	and 2 shou alth and N 27 is mar er traumat		19a. Informant's Name/Relationship ( Stephanie Stevenson	Type. Print)	19b. Mailing Address (Street and Number or Rural II 6051 Cecil Avenue Baltimore						ıral Route Number, City or Town, State, Zi			Zip Code	<del>)</del> )
Baltimore,	Pages 1 anent of He ant: If item ury or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification of the control	20b. Pl	20b. Place of Disposition (Name of cemetery, crematory or other place)  Date							20c. Location - City or Town, State			
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	Examiner	er.		. Hyp		sion									
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O. Box 687	attending properties	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	pf pregnar 2 □ F <i>e</i> tal	f pregnancy □ Fetal death me of death  3□Ectopic pregnancy 5□Other (specify)						23d. Date of delivery Month Da			Year	
ds, P.	w requires triat title or been signed by the should be detached	by	Part II. Other significant conditions of	contributing to death be	ut not resu		derlying cau	ise given	in Part I.		23e. Did to		8-6		use of death?
Vital Records,	cate has been page 2 shoul	Completed	Al cahalle	Dement	a					_ (	24a. Was a	an 2	24b. Were a prior to death?	tutopsy fir completi	ndings available on of cause of
		Be C	25. Was case referred to medical examiner?							of Death (0	1□ Yes Check only o		1 □ Ye	s 2/20	40
ion or	within 24 hours after death.  To the Funeral Director, After this certification completely filled in by the funeral director, a	ation: To	1D Yes 2 No  27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie  28a. Date of Injui (Month, Day	ry	ER/Outpatient 28b. Time of Injury		Other:	4 □ Nurs	280		y one) esidence 6 □Other (Specify) se how injury occurred			
DIVISION	s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	iry - At hor c. (Specify,	me, farm, stre	et, factory, o	office		28f	. Location (S City or Tow	on (Street and Number or Rural Route Number, Town, State)			te Number,	
i de	in 24 hour the Funer pletely fill	edical	29a. Certifier (Check only one)  Lactorifying Ph 2 Medical Exam	of my know examinati ated.	vledge, death ion and/or inv	restigation, li	n my opi	nion, death	place, and occurred	d due to the d at the time,	cause(s) and pla	id manner a ace, and du	as stated. ue to the c	ause(s)	
)		Σ	29b. Signature and tiple of certifier	fer			1	Jicense r	number 1726		2	29d. Date s	igned (Mor	-	
	8	30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)  Kevin G. Seaman M.D. 300 St Paul Pl. Baltmore, MS							212	.62					
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 2 5 20	07 32 Registra	ar's Signati	Signature							D 2:-02		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fb 9869 7-25-07 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY ROSE 19 2007 KATZ 7:30 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE If Under 24 Hrs. 8. Date of 1902 Hours Min. 09/03/1904 Birthplace (State or Foreign Country)
 RUSSIA 5. Social Security Number Age (In yrs. last birthday **Funeral** Days 1 ☐ M 2 😿 F Months 204-01-2090 104 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once. 10c. City, Town or Location 10d. Inside City Limits 10b. County Funeral Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? <u>725 MT. WILSON LANE</u> 21208 U.S.A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry COMPTROLLER OFFICE Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND ADMINISTRATIVE ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ BARNETT <u>POLAKOFF</u> <u>RACHAEL</u> HARRIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 DROHOMER PLACE - BALTIMORE, MD 21210 RENEE COHEN / DAUGHTER 20b. Place of Disposition (Name of ANSHE LEMONAL) 20c. Location - City or Town, State BALTIMORE, MD 20a. Method of Disposition Date 07/22/2007 1 Burial 2 □ Cremation 3 □ Removal from State (AITZ CHAIM) 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrhythm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner he law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ distruct ve pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed heart 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No congestive 2 100 Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊡No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? after death. I Director: After the 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral I 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 2 To the I 2

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

aren L. Baltt, M.D

Babitt,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. your old court road, suite 301 32. Re rar's Signature

29c. License number

00058676

29d. Date signed (Month, Day, Year)

Baltmore

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 26, per MD, g869, 7/25/07 TT Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 20. 2007 11:20a <sup>™</sup> Robert Louis Kapela July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore or , if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 28,1946 620 S. Montford Avenue City 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F 61 Maryland 212-48-1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No MD N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 620 S. Montford Avenue 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Inspector General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Frank Kapela</u> Louise Kluczynski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louise Kapela- Mother 623 S. Montford Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 7-24-2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Services 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MRSA Immediate Cause (Final prieumonia o months disease or condition resulting in death) Due to (or as a con-equence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of

2□ No

Physician /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or a may Injury or other traumatic event, the Medical Examiner must be nooce.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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Completed

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/Medical

attending physician and for use as the burial-transit been signed by the s should be detached funeral ours after death.

neral Director: A
filled in by the fu To the Hospital o within 24 hours aff To the Funeral D

or Attending Physician: The law requires that the death certificate be executed

certificate

this

After

Division or Vital Records, P.O. Box 68760.

Examine Physician/Medical Completed by Be Certification: To

2 😾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Tiya late , Medicai Poctor 14es-000 July 23, 2007

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miya Patemiti, The Johns Hopkins Hospital, 400 North Wolle Street, Baltimore, Maryland 21287 32. Resistrar's Signature

			Amend Item 1 For 1 State	se Type or Print in Black Indelible Ink. Ensure s 25,27,28a-f per ME. 2869,07/17/07dhi a State of Maryland / Department of Health and mend Item 23a per dr. 2869,07/17/07d Certificate of Death	d Mental Hygiene
			State Registrar  1. Decedent's Name (First, Middle,		2. Date of Death 3. Time of Death
1 49	Physicia	an	1. Decedent's Name (7 iist, Middle,	Lasti	Month Day Year 4:29A M
	/Medic Examin	2.0	4a. Facility Name (If not institution,	give street and number)  4b City, Town, or Location of De	-019
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	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hours N	Ain. (Month, Day, Year) Country)
M.	Director	4	Usual Residence of Decedent	100M 2LIF 55 Yrs.	10ct 28, 1951   Waryland
	land ow at		10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	Many a-f sh ified	tor	ma 1	N/A Baltimore	1 □¥€S 2 □ No
	or 28	Direc	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath w	Funeral Director	1803 Kie	198 AME 212	? (Specify Yes or No- 14. Race - American Indian,
	item item	un-	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?  If Yes, specify Cuban, Mexican, Pi  If Yes Specify Cuban, Mexican, Pi  If Yes Specify Cuban, Mexican, Pi	verto Rican, etc.)
936	urs af al", or Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:	Specify: Black
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ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationshi	ip (Type. Print)  19b. Mailing Address (Street and Number of	r Rural Houte Number, City or Town, State, Zip Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	20b. Place of Disposition (Nambol cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Ħ	permit. Pages Department of Important: If it any Injury or conce.		4 ☐ Donation 75 ☐ Other (Sp 21. Signature 1 Funeral Service L	1000000	270 67 HILDON Page
Ba	permit. Departr Importa any Inji		Jon 4/1 11	med Garage Marc	h Funeral Home Balto. md. 21229
			23a. Pari 1. Epter the disease, or o	complications that caused the death. Do not enter the mode of dying, such as car only one cause on each line. <b>Cerebral Hypoxi</b>	
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1	/Medical		resulting in death)	Due to (or as a continuence of):	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1242 PM 2007 HEODORE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Baltmore N/A Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min Months Days Hours M 2□ F 75 085-30-0803 November 27, 1931 Spain Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □ Yes 2 No Ocean View Director Delaware Sussex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19970 U.S.A. 38141 Blue Heron Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 72 hours after 1 ☐ Yes 2 No Maryland 21215-0036 Specify. Specify: þ White 3 ☐ Widowed 4 ☐ Divorced ear or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction **Brick Layer** permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other transmitted. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Manuela Santamaria Manuel Martinez ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2516 Holly Springs Ct. Ellicott City, Maryland 21043 Son Mr. Theodore Martinez 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Dispesition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 07/25/07 Sykesville, Maryland All County Cremation Services, Inc. ure of Funeral 22. Name and Address of Facility Lidense Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 X11101293 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise Stage Chronic Obstructive Pulmon Immediate Cause (Final **Physician** End tears disease or condition resulting in death) /Medical Due to (or as a sequence of) Examiner Sequentially list conditions. Due to (or as a consequence of). is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□No 1 ☐ Yes 2 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 26f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

P.O. Box 68760, Division or Vital Records, Hospital or Attending Physician: 24 hours after death e Funeral Director: To the within 24

Baltimore,

State Registrar

31. Date filed (Month, Day, Year) JUL 2 5

29b. Signature and title of



who completed cause of death (Item 23a) (Type, Print)

Greene St.

Kriedl

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

21041

Baltimore, MD

29d. Date signed (Month, Day, Year)

4007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Michael Joseph Miktus 19 2007 10:34pm /Medical 4a. Facility Name (If not institution, give street and number)
Gilchrist Center for Hospice 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson 9. Birthplace (State or Foreign Country)
New Jersey 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 140-36-9891 62 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits MĎ Baltimore Cockeysville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be r 10713 Lancewood Rd. 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Nes 2 □ No If Yes, Give Year or Dates: 1965–67 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify. White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 <u>ک</u> 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Telephone Engineer Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Miktus Agnes Catherine Kozak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Miktus/wife 10713 Lancewood Rd.Cockeysville,MD21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages.
Department of H
Important: If ite
any Injury or of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 7/21/2007 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 8717 Green Pastures Dr. Towson, MD 21. Signature of Funeral Service Licensee n01358 Cremation+ Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nnici **Physician** monters /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9 Unknown 9∏Unknown care nas been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 POther (Specify) NOS PL CO Certification: To 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

State

29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 2 5

Registrar DHMH 17 Rev 1/2001 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

58303

29d. Date signed (Month, Day, Year)

July 20 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Earl Robert Myers 10:55 AM 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Good Samaritan Hospital 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/5/1929 9. Birthplace (State or Foreign Days 220-24-7304 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 7208 1/2 Harford Rd. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 by Yes 2 □ No If Yes, Give Year or Dates! 9 4 7 - 50 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Upholsterer Upholstery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Albert Myers Mildred Vangard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Myers/son 5411 Hillburn Av.Baltimore,MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 7/25/07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8717 Green Pastures Dr, ma1358 Cremation + Funeral Alternatives Towson, mD21286 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) >205,5 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumonia Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

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/Medical Examiner signed by the attending physician and be detached for use as the burial-tran

**Physician** 

**Physician** 

/Medical

Examiner

**Funeral Director** 

Completed by

Be

ဥ

**Funeral** 

Director

If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after or thent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

death with the Maryland

P.O. Box 68760, Division or Vital Records. this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica To the Hospital within 24 hours a

Examiner

Physician/Medical Completed by Be 2 Certification:

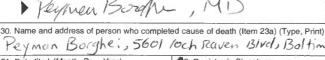
Medical

29a. Certifier

341 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie



and manner stated

29c. License number RES-000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

7,20,07

Peyman Borghei, 5601 lock Raven Blvd, Boltimore, MD. Good Samaritan Huspital

2. Registrar's Signature JUL 2 5 2007

		1	For State Registrar	State of Marylan		rtificate of L			eg. No.		23035			
-7 -85	Physicia	-	I. Decedent's Name (First, Middle, Last)	uin D. Morta	Tr			2. Date of Deat Month	Day	Year	3. Time of Death			
	/Medic	al	LTV  la. Facility Name (If not institution, give s	vin R. Martz	Jr.	4b City Town or	Location of Death	July	-	2007 10.13 A M				
	Examin	C.	BAIL image wishingte		ater	GLEN	Buen	iE			LUNDEL			
24	Funeral Director		5. Social Security Number 5. Sex 213 20 4499	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 20	, 1925	9. Birthp	lace (State or Foreign try) rland			
	and ow t		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits			
	Mary a-f sho ified a	tor	Maryland Anne A	rundel B	altimo	re					1 ☐ Yes 2 <b>K</b> No			
	th with the 23a or 28a 1st be not	ā	10e. Street and Number 624 Douglas Stre	et			225		0g. Citizen of V	Α.				
920	be filed within 72 hours after death with the Maryland Ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	<ul> <li>12. Was Decedent Ever in U Armed Forces?</li> <li>1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:</li> </ul>		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2☑ No		ecify Yes or No- Rican, etc.)	Specify	e - Americ k, White, Whi	etc. te			
5-0	72 ho "natur	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of work	king	16b. Kind of Bu	usiness/Ind	dustry			
121	within lene. than the Me	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		ctriction	<b>'</b>		N.S.	Α.				
d 2	other vent, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)  Emma Itter							
ylar	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the M	To E	Irvin	Itter Aural Route Number, City or Town, State, Zip Code)			0-4-1							
, Maryland 21215-0036	nd 2 salth ar 27 is r trau		19a. Informant's Name/Relationship (Tyn Reba Martz / wif	re, Mary	/land	21225								
Baltimore,	permit. Pages 1 a Department of Hei Important: If item any Injury or othe		City or To											
tim	permit. Pages Department of Important: If it any Injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature Funeral ervice License	_	aryland									
Bal	permit. Departr Importa any Inj		21. Signaturi Fulletai entite scense			22. Name and Addre								
		П	23a. PartT. Enter the disease, or compliant shock or heart failure. List only or	cations that caused the dea	4001 Ritchie Highway Baltimore, Maryland 21225  caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line.  Approximate Interval Between Onset and Death									
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	^	ساد	on ia					Onset and Death			
	3	Jer.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):									
	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	)										
60,	be execian a	al Ex	resulting in death) cast	Due to (or as a consec	quence or):									
68760,	ficate physi s the I	edical		J										
.O. Box (	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)								ery Day Year			
<u>α</u>	ires that t signed by d be detad	þ	Part II. Other significant conditions con	N .	sulting in the	underlying cause giv	ven in Part I.				the cause of death?			
COL	iw requ	Completed	Vanal	Cail	ure			24a. Was			opsy findings available ompletion of cause of			
Re	ding Physician: The lav. n. After this certificate has funeral director, page 2	omo							rmed?	death?	2 No			
/ita	clan: ertifica ector, I	Be	25. Was case referred to medical examiner?	Hoopitali			26. Place of Dea	ath Check onl o	ne					
or/	Physiclan: this certific ral director,	P	1 Yes 2 No	28a. Date of Injury	ER/Outpatie	of 28c. Inju	ry at	lome 5 Resid			ify)			
on	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? ]Yes 2 □ No		. ,					
1   Yes 2   No   No   No   No   No   No   No									ber or Rur	ral Route Number,				
	le Hospita 124 hours le Funeral	27. Manner Death   Month, Day Year)   Manner Death   Month   Manner Death   Month   Manner Death   Month   Manner Death   Month   Manner Death   Month   Manner Death   Month								stated. to the cause(s)				
	To the within To the comp													
/	Kt]		30. Name and a ress of person who c	ompleted cause of death (Ite	m 23a) (Type	e, Print)	nonlies	الن رأ ٥٠٠	4.4	1 6	Dea Alex			
/	VOY.		31. Date filed (Month, Day, Year)	32. Registrar's Sign		edical (	-euter	30	Hosp	retal l	prive Burnik			
*	St Regist	ate trar	JUL 2 5		J. J.	Coule								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		oartment o e <i>rtificate (</i>				iene		
	1		Registrar     Decedent's Name (First, Middle, Last)			or imouto (	or Bourn		. Date of Deat	th		3. Time of Death
	Physici			A. McK	enzie				July	$2\overset{\text{Day}}{3}$	2007	1:10A.M
	/Medic Examin	- 1	4a. Facility Name (If not institution, give s			4b. City, Tov	n, or Location	of Death		<del></del>	County of Death	
	LXaiiiii	Ç.	Gilchrist Center	c		Tow	son				Baltimo	
	Funeral Director		5. Social Security Number 220 - 74 - 53333 6. Sex	м 21 F 7. Age (In	yrs. last birthda Yrs.	Months   Da	ear If Unde ays Hours	Min.	. Date of Birth (Month, Day, Aug 29	$\stackrel{\scriptscriptstyle Year)}{,} 1^{\circ}$	9. Birthp Cour 9 5 8 Mar y	place (State or Foreign http) Land
	ryland how Lat		Usual Residence of Decedent  10a. State  10b. County  m/a	10	c. City, Town or Balti						1	10d. Inside City Limits 1 X Yes 2 □ No
	8a-f s	Funeral Director	·		Daici					0- 0:1:-	en of What Cour	
-	a or 2 be no	声	10e. Street and Number 1001 Iris Aven	10		10f. Zip Co	205		'	og. Onz		-
)	eath rs 23 must	eral		12. Was Decedent Ever	r in U.S. 1	3. Was Decedent If Yes, specify		rigin? (Specif	fy Yes or No-	1	14. Race - Americ	can Indian,
336	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	٥	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify  1 ☐ Yes 2  2			can, etc.)		Black, White, Specify:	White
215-0036	filed within 72 hou Hygiene. ther than "natura ent, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	16a. De (G.	cedent's Usual O ive kind of work d e. DO NOT use n	ccupation one during mo etired)	est of working		16b. Kin	nd of Business/In	dustry
2121	d with giene er tha , the	ĕ	9th			Home 1						Home
altimore, Maryland		To Be (	17. Father's Name (First, Middle, Last) Ervin McKenzie				1		First, Middle, I Brash			
ary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	, i	19a. Informant's Name/Relationship (Ty)	oe. Print)	19b. Ma	ailing Address (Si	reet and Num	ber or Rural I	Route Number	r, City or	r Town, State, Zij	o Code)
ري ح	s 1 and if Health item 27 other tr		Linda Robak (si			Jeanne sposition (Name of		<u>Avenue</u> Dat			ore, Mo	. 21222
0	Pages 1 Tent of H Int: If ite		20a. Method of Disposition 1X Burial 2 □Cremation 3 □R		cemetery, c	rematory or othe	r place)					Marylan
Baltin	permit. Pages Department of Important: If it any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligens	90	JC.JCa	22. Name and A	ddress of Fac	iik aczo	orowsk	î F	Tuneral	Home, P
->			23a. Part1. Enter the disease, or complishock, or heart failure. List only or		death. Do not							Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	real	cance						Onset and Death  Control  Cont
ı	Examiner	_	Sequentially list conditions,	Due to (er ee n ee								
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events	onsequence of):	Addition of the second of the							
8760,	cate be executed physician and the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as a co	Due to (or as a consequence of):							
587	ficate physi sthel	edical		l								
Division or Vital Records, P.O. Box	The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 18 months? 1 □ Yes 2 D No 9 □ Unknown	3c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic pregi 5 □ Other (speci				2	23d. Date of deliving Month	rery Day Year
<u> </u>	that the	/ Ph	Part II. Other significant conditions con	ntributing to death but n	ot resulting in th	e underlying caus	e given in Par	t I.	23e. Did to	bacco u	se contribute to	the cause of death?
rds	quires n sign uld be	d by							1 □ Y	es 2	No 3□Pro	bably 4 □Unknown
000	aw requints been si	Completed							24a. Was a		24b. Were aut	opsy findings available ompletion of cause of
ž	The lay	E O							perfor		death? 1 ☐ Yes	2□ No
ita I	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					ce of Death (	(Check only or	ne)		
7	chysic this co	2	1 ☐ Yes 2 No		2 ER/Outpa						6 Dther (Spec	ity) NOSP(Cl
sion (	ending F sath. or: After he funera	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Inju	M M	Injury at Work? 1 ☐ Yes 2[	□No	3d. Describe h			
DIX	Hospital or Attended hours after death Funeral Directors stely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (		street, factory, o	ttice	28	3f. Location (S City or Tow			ral Route Number,
		Medical (	29a. Certifier (Check only one)	sician: To the best of n ner: On the basis of ex and manner stated	amination and/o	eath occurred at or investigation, in	the time, date my opinion, d	and place, ar leath occurre	nd due to the o	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complex	M	29b. Signature and title of certifier			29c. L	icense numbe	2	2	29d. Dat	te signed (Month	, Day, Year)
)			> Glean	いつ			1 200	0	(	70(	1250	+007

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AND J CHAWES WD 6701 N CharlOST TONSON MD 21204

JULY 21, 2007

Physician /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

= State Registrar			Certifica	te oi L	Jeath	R	eg. No.			
. Decedent's Name (First, Middle, Last)						2. Date of Dear Month	th Day	Year	3. Time of Death	
Frank J.	Misla	ık				July	ži,		5:20P.	
a. Facility Name (If not institution, give s	street and number)		4b. City	, Town, or	Location of Deat	h	4c. Cc	ounty of Death	1	
Stella Maris Ho	spice			mon i	ium		Ва	altimo	re	
. Social Security Number 6. Sex	7. Age (	In yrs. last birt	Months	er 1 Year Days	If Under 24 Hrs Hours Min.	(Month, Day	Year)	9. Birth Cou	place (State or Foreig Intry)	
217-14-5230	- W 2	84	Yrs.			Dec8,1	922	Mar	yland	
Jsual Residence of Decedent  0a. State 10b. County	1	0c. City, Town	or Location						10d. Inside City Limits	
Md. n/a	,	D	oltimo	vr o					1X∑Yes 2 No	
Oe. Street and Number	1	Б	altimo 10f. Zi	ip Code		1	0g. Citizer	n of What Cou	intry?	
712 South Decke							•	J.S.A.	•	
	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C					Specify Yes or No-		. Race - Amer	ican Indian,	
1 ☐ Never Married 2 ☒ Married	Armed Forces?				to Rican, etc.)		Black, White, etc.			
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give W Year or Dates:	W II	1 ☐ Yes	2LXNo	Specify:		Sį	pecify:	White	
15. Decedent's Educ (Specify only highest grade	cation	16a.	Decedent's Usi	ual Occupa	ation during most of wo	rkina	16b. Kind	of Business/I	ndustry	
Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT (	use retired	) )	inity				
5th								S.P.S	•	
7. Father's Name (First, Middle, Last)						me (First, Middle, i		,		
Benjamin Mislak								enska	·	
19a. Informant's Name/Relationship (Ty)	oe. Print)	19b.	Mailing Addres	ss (Street a	and Number or A	ural Route Numbe	r, City or T	own, State, Z	ip Code)	
Rita Mislak (wife) 712 S. Decker Ave. Baltimore, Md. 21224										
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State										
·	omoval from State	20b. Place of cemeter	Disposition (Na y, crematory or	ame of	*	Date	20c. Loca	tion - City of	own, State	
·	emoval from State	cemeter	y, crematory or tanisl	ame of other plac .aus	Cem7-2	6-2007B	alti	more,	Maryland	
1 ☑Burial 2 ☐ Cremation 3 ☐ R		cemeter	tanisl 22. Name a	ame of other place. AUS	Cem7-2	6-2007B zorowsk	alti i Fu	more, neral	Maryland Home,PA	
1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemeter	tanisl 22. Name a	ame of other place. AUS	Cem7-2	6-2007B	alti i Fu	more, neral	Maryland Home,PA	
1 XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	ee S	St. S	tanis1 22. Name a	ame of other place. aus and Address Dund	Cem7-2 Ss of Facilly ac lalk Av	6-2007B zorowsk e. Balt	alti i Fu imor	more, neral	Maryland Home, PA 21222  Approximate Interval Between	
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1 Suburial 2 Cremation 3 R 4 Donation 5 Other (Specify)  11. Signature of Funeral Service License Shock, or heart failure. List only or mendiate Cause (Final lisease or condition esulting in death)  Sequentially list conditions, any, leading to immediate and initiated events esulting in death)  FFEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	cations that caused the cause on each line.  PROSTATE  Due to (or as a complete to the complet	cemeter St. S  The death. Do not consequence of con	22. Name a 1201 not enter the mo	ame of account of acco	Cem7-2 ss of Facilivac lalk Av	6-2007B zorowsk e. Balt	alti i Fu imor	more, ineral	Maryland Home, PA . 21222  Approximate Interval Between Onset and Death	
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Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 721

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Creed Edward Mourey

reed Edward Mi	1	For State Of Maryland / Department of Fleath and Mental Fig.	Reg.	No.	
Physicia	n/	. Decedent's Name (First, Middle,Last)	2. Date of Death Month	ay Year	3. Time of Death 0841 hrs
Medical Examir		Creed Edward Mourey  la. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	July 17, 200	4c. County of Dea	
	Н	1200 Block Gusryan Street Baltimore			
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min.			eign
Director	-	159-56-8006   1x   M 2   F   32   Yrs.   Jual Residence of Decedent	6-7-1	975	Country) Pa.
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ğ	Md. Baltimore Hawthorne Park	140-	. Citizen of What Co	1 Yes 2 X XNo
e Mary or 28a-	Director	10e. Street and Number 10f. Zip Code 2214 Redthorne Road 21220	109		i
with th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Status)	pecify Yes or No-		erican Indian, Black,
death	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
rs after ural",	۔ ھ	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of vices)	work done	Specify: 16b. Kind of Busines	White s/Industry
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ired)		
003( within jene.	dwo	12th lyr Owner/Operator	e (First, Middle, Ma	Landsca	ping Comp.
21215-0036 auldbe filed within 7 Mental Hygiene. marked other than c event, the Medical	BeC		J. Gra		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumante event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, Sta	
ore, MD s 1 and 2 sho of Health and If item 27 is	-	Vicky Paradise (mother) 680 Seawave Court	Baltim Date	ore, Mai	ryland21220 or Town, State
Baltimore, permit. Pages I are Department of Har Important. If item night or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or other place)			
Baltimo permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ka	czorows	ki Fune:	al Home, PA
		The Dundalk A	ve. Bal	timore,	Md. 21222
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arres	st, Shock, of Heart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hanging  Due to (or as a consequence of):			
	١	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			<del></del>
	Examiner	cause. Enter Underlying Cause c.			
ted d ansit		events resulting in death) Last  Due to (or as a consequence of):  d.			
e executed cian and rial - transi	Medical	UNPENDED AMENDED			
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Box 687 e death certific the attending ped for use as the	iciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	larioy		
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	Physician/	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
P.O. ss that the gened by the detac	Ď	Fart II. Other Significant Continuous Continuously to County for Counting III are analysing access growth Cart	1 Yes	2 V No 3 F	Probably 4 Unknown
rds, require been si hould b	Completed		24a. Was a		autopsy findings available to completion of cause of
eco he law ate has age 2 s	dwo		perform	med? death	1?
	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nurs			
of Vid Physic er this	0	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nurs  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	•	Residence 6 V O	ther: Scene
Sion o	Certification: T	1 Natural 5 Pending FOWND: FOUND: 1 Yes 2 ✓ No	Subject hang	ged self	
Vision Atte	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City
Di spital hours a neral I		4 Homicide determined (Specify) Park/Recreation Area  29a. Certifier A Contificion Physician. To the best of my knowledge death occurred at the time date and place are		ate) usryan Street, Bal	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at the time, date	e(s) and manner as: and place, and due t	o the cause(s)
To Con	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
7		O.C.M.E.		July 17, 2007	
8		30. Name and address of person who completed cause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
	tate	31. Date filed (Month, Day, Year) 32. Registr's Signature			
Regis		JUL 2 5 2017 Mayer & Agrees			
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		Registrar  1. Decedent's Name (First, Middle	e, Last)		061	2. Date			Reg. No.		3. Time of Death		
Physic /Medi		Willie Clay	ton Oxer	ndine				July	18 a	Year 2007	155 P M		
Exami		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or Location of Death			4c. Coun				
		BAUTHORE WA				GENT			AA COUNTY				
Funeral Director		5. Social Security Number 246-48-9220	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 06/26)	/ Year) /1921	9. Birthp Court	place (State or Foreign ntry) NC		
and w	ral Director	Usual Residence of Decedent  10a. State 10b. County	ty, Town or Loc	ation			10d. Inside City Limits						
Maryl -f sho		MD Anne	Arundel	na					1 ☐ Yes 2 ☐ No				
or 28a		10e. Street and Number				10f. Zip Code		T	10g. Citizen o	f What Cour	ntry?		
23a c ust b		578 6th Stre	eet			2112	2		U.S.A.				
er des items	Funeral	11. Marital Status	Armed Fo		.S. 13. V	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ ack, White,			
ırs aft al', or xami	þ	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes If Yes, Gi Year or D	ve _	1	☐ Yes 2☐ No	Specify:		Spec	ify: Ame Ind	rican		
72 hou natura fical E	sted	15. Deceden	t's Education st grade completed)		16a. Deced	ent's Usual Occup	ation	ving I	16b. Kind of				
ne. han "	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)			during most of worl i)	(ing					
filed w Hygie ther t		1 2 17. Father's Name (First, Middle,	l ast)		Вох	Maker	18. Mother's Nam	e (First Middle	Packa Maiden Surna				
ld be ental ked o	To Be	Johnnie Oxer	ŕ					a Lowe		<i></i>			
shou and M s mar umat	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailing	Address (Street	and Number or Ru			n, State, Zip	Code)		
and 2 ealth a n 27 is		Clark Oxendin	ne / Son				reet, P	asadena	a, MD	2112	2		
ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐Removal from		Place of Dispos cemetery, crem	ition (Name of atory or other plac	re)	Date	20c. Location	•			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at once.		4 Donation 5 Other (S		Ce		lll Cem		24/07					
permi Depar Impor any ir		21. Signature of Funeral S	Licensee								Home, PA		
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			For State		State of Mai	ryland / [		ent of H ate of L		Mental H	ygiene Reg. No	211111	23091
	57.5		Registrar  1. Decedent's Nam	ne (First, Middle, Las	it)		Oorame			2. Date of D	eath		3. Time of Death
	Physicia /Medic		Joseph	nine	J.		0we	n		July	24 <sup>Da</sup>	2007	2:30 A™
	Examin		,	(If not institution, give					Location of Dea	ath		4c. County of Death	
			5. Social Security !	rie Hunt D	ex 7. Age	(In yrs. last bii		utherv	IIIE If Under 24 Hr	s. 8, Date of E	irth	Baltimor	Dlace (State or Foreign
	Funeral Director		340-18-6		□ M 2 1 8		Yrs. Mon	ths Days	Hours Mir	July 1	7, 19	923 Cou	Illinois
pue	2 3		Usual Residence of 10a. State	of Decedent 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
Mary	ied a	tor	MD	Baltimor	e	Luther	rville						1 □Yes 2 XNo
att di	or 28a e notii	Director	10e. Street and Nu					. Zip Code			10g. Cit	izen of What Cou	ntry?
ath wil	23a c	ral	308 Merr	ie Hunt D				21093			USA		
G K 1 K 1 D-0000 filed within 72 hours after death with the Marvland	I health and Mental Hygene. Health and Mental Hygene. Health ard Mental Hygene. other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Mar  3 ☒ Widowed	rried 2 Married	12. Was Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:			ecedent of Hi specity Cuba es 2∭No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or Nerto Rican, etc.)	10-	14. Race - Ameri Black, White, Specify:	
	atural			15. Decedent's Ed	ucation	16a	. Decedent's	Usual Occupa	ation		16b. K	ind of Business/Ir	
hin 7,	e. Medi	Completed	(Spe	condary (0-12)	de completed) College (1-4or 5+			f work done o DT use retired	furing most of w	orking		timore Co	•
, ja	lygien her th nt, the			(5)		Te	eacher	Т	19 Matharia Nic	ame (First, Midd		lic Schoo	ols
9 9	snound be filed within is marked other than aumatic event, the M	Be c	Walter J	e ( <i>First, Middle, Last)</i> ใลกบ <b>ร</b> เษ					Alice 1		ie, iviaider	i Surname)	
should be	nd Me mark matic	<b>P</b>		Name/Relationship (7	Type. Print)	195	o. Mailing Add	iress (Street a			nber, City o	or Town, State, Zi	o Code)
1 and 2	alth a		James E.	Sachse	/ son	2	Inver	in Circ	cle; Tin	nonium,	MD 21	1093	
Pages 1.	If item or oth		20a. Method of Dis	sposition	Removal from State	cemete	of Disposition ery, crematory	or other plac	i i .	Date		ocation - City or T	,
	rtment rtant: njury		4 ☐ Donation	5 Dther (Specify	/)	Dulaney		Mem Gar ne and Addres	dens 7/2	26/07		onium, MO	
	Department of Health a Important: If item 27 is any Injury or other training.		21. Signature of F	uneral senvice/Licen	see				n Funera	al Home		050 York owson, Mi	
	200		23a. Part1. Enter	the disease, or compart failure. List only	olications the caused to	he death. Do						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate interval Between
P	hysician		Immediate Cause disease or condition	e (Final ion	a. Transition	unl Ce	11 Car	MINIS	of my	Rever!	Oelu.	2	Onset and Death
	/Medical xaminer		resulting in death)		Due to (or as a								
	is = =	er	Sequentially list of	onditions,	b. Due to (or as a	consequence	uf):	_					
Patric	nd ransit	Examiner	cause. Enter Und Cause (Disease o that initiated event	IS 🔳	C								
cor co,	oian ar		resulting in death)	Last	Due to (or as a	consequence	of):						
Sold at a land	physic s the b	edical			d								
be death certif	The first hospital or wearing tripschart, the fair requires that the death continues are be executed.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was deceded in the past 12 1 ☐ Yes 2 9 ☐ Unknown	st 12 months?  4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year		
Lo, L.	signed by	by	Part II. Other sign	nificant conditions o	ontributing to death but	not resulting i	in the underly	ing cause give	en in Part I.		3e. Did tobacco use contribute to the cause of death?  1 ☐ Yes ②★No 3 ☐ Probably 4 ☐ Unknown		
	been	etec								24a. Wa			opsy findings available
The late	te has	Completed			,	<del></del>				- au	topsy rformed?	prior to co	ompletion of cause of 2 <b>≨</b> No
110	ertifica ctor, p	Be C	25. Was case refe examiner?	erred to medical						eath (Check onl		, , , , , ,	
by six	this ce	To	1 ☐ Yes 2		Hospital: 1 Inpatien			DOA Oth	4 🗀 Nursing			6 □Other (Special	fy)
	After funera	tìon:	27. Manner of Dea	atn 5  ☐ Pending investigation	28a. Date of Injury (Month, Day		Time of Injury M	28c. Injun Worl	y at <br Yes 2 □ No	28d. Describ	e now inju	iry occurred	
Affen	er deat ector; by the	Certification:	2 <sup>\</sup> Accident 3 Suicide 4 Homicide	6 ☐ Could not be	I	y - At home, fa	arm, street, fa			28f. Location	(Street at	nd Number or Rui	al Route Number,
5 <u>\$</u>	rs afte	Cert	, Ditemore		Danaing, oto.	(Сроспу)				J Sity of 1	own, olds		
) H	in 24 hou he Funei pletely fil	Medical	29a. Certifier (Check only one)		ysician: To the best of niner: On the basis of and manner stat	examination a		ation, in my o	pinion, death oc		e, date an	nd place, and due	to the cause(s)
Ē	To t	Σ	29b. Signature an	nd title of certifier		MO		29c. Licens			29d. Da	ate signed (Month	Day, Year)
)	F )		The l				(Toma Data)	173	3409			7/27/07	
H	A		30. Name and add		completed cause of de	F 57	11 Ro	1 4141	5 UM	vertle t	14 2	21093	
	Sta		31. Date filed (Mo		32. Registra		, 1	. P					
	Registr	ar		JUL 2 5	2007	was Si	400	3					

FRANKLIN Rosedale Square HOSPITAL center If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/12/1934 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 214-34-2665 73 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at Director MD HARFORD **JOPPA** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or Funeral 809 CHATFIELD ROAD 21085 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Kalhry e filed within 72 hours after d Il Hygiene. other than "natural", or Item 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: \$ S Wildowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other that any Injury or other traumatic event, the once. CLERICAL Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SHAPIRO DORA ပ Sboar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE\_FORD\_/\_SISTER 809 CHATFIELD ROAD - JOPPA, MD\_21085 Baltimore, 20a. Method of Disposition HEBREW YOUNG MEN'S 07/22/2007 1 Burial 2 □ Cremation 3 ☐Removal from State WOODLAWN, MD 4 ☐ Donation 21. Signal of Juneral Service Licens 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed CLOSTRIdium and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed this certificate 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 ☑ No 1 npatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: After 5 ☐ Pending investigation (Month, Day Year) 1 Natural To the Hospital or within 24 hours after death.

To the Funeral Director: After a contact of the funeral blied in by the funeral or the funer 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide

determined

muneses

2007

MA

MD

4 Homicide

(Check only one)

30. Name and add

29b. Signature and title of certifier

31. Date filed (Month Day, Year)

29a, Certifier

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

KATHRYN

**Physician** 

/Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 11 per fb 9869 7-25-07 vt
State of Maryland 7 Department of Health and Mental Hygiene

Certificate of Death

**OSBORN** 

4b. City, Town, or Location of Death

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 DIFFICILE COLITS 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square PRIVE BALTIMORE Maryland 32. Registrar's Signature **ORIGINAL** 

2. Date of Death

Month

07

Day

9

Year

Baltimore

14. Race - American Indian,

Specify:

I.R.S.

WHITE

ZAREWITZ

- City or Town, State

07

4c. County of Death

3. Time of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 ☐ Yes 2√☐ No

828 A M

State Registrar

			1 - For State Registrar	State of M	laryland		artment o rtificate			ind M	ental Hy	giene		
Г	Dhyoisi		1. Decedent's Name (First, Middle, Las	t)							2. Date of Do	eath Day	/Year	3. Time of Death
	Physici /Medic		James Ernest Pickett								July	2	0 2007	12:30 P <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give Lorien Nursing Home				4b. City, Tor	<b>-y</b>				Car	roll	
	Funeral Director		5. Social Security Number 6. Security Number 12 18-14-5130A Usual Residence of Decedent	7. A	ge (In yrs. Ia:	st birthday) Yrs.	If Under 1 \ Months D	Year ays	If Under a	Min.	8. Date of Bi (Month, D Jan 30	1923	9. Birth Co Mary 1	nplace (State or Foreigr untry) and
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	e Mar a-fst	ctor	MD Carroll Mt. Airy								1 ☐ Yes 2			
980	h with the	al Director	10e. Street and Number 7936 Bennett Branch 1								og. Citizen of What Country? USA			
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "natural", or Items 23a or 28a-f show atic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	Ever in U.S. ? No		Vas Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2☆No Specify:					0-	14. Race - American Indian, Black, White, etc.  Specify: Wiite		
215-0	hin 72 ho a. an "natur Medical	Completed		highest grade completed) (Give kir life, DC 0-12) College (1-4or 5+)				dent's Usual Occupation kind of work done during most of working OO NOT use retired)				16b. Kind of Business/Industry		
2	ed wit ygiene yer the	Соп				Electr	ici <i>a</i> n							el Hospital
/land	should be filed withir and Mental Hygiene. Is marked other then aumatic event, It e Market	To Be	17. Father's Name (First, Middle, Last) Harry W. Pickett						18. Mothe Florri		(First, Middle linix	, Maiden	Sumame)	
Mary	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print)  Janet Barnes (Step-Daughter)  19b. Mailing Address (Street and Number or Rural Route Number, 414 Salem Bottom Rd. Westminster, MD 2							21125	r_Town, State, Z	lip Code)		
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Healt Importent: If item 2 eny injury or other once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		cen	ce of Dispo netery, cren O <b>liv</b> et	sition (Name natory or other	of ir place		23/200	eate )7		cation - City or lerick, M	
Balti	permit. I Departm Importer eny inju		21. Signature of Funeral Service Licen		, 110	Pur	. Name and A	Addres	s of Facility Funera	1 Han	ne and C	remato	ory, P.A.	
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	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):											
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876	cate be ex physician the buria	dlcal		d										
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Festal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown							23d. Date of delivery Month Day Year				
<u>α</u>	quires that the signed by ald be detacted	by	Part II. Other significant conditions of	Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac								cco use contribute to the cause of death?		
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Vital	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	33,77					26. Place	of Death	(Check only			
	Physicien: this certific ral director,	ု	1 Tyes 2 No	Hospital: 1  Inpati		R/Outpatien		Othe	4 Nu				6 Other (Spec	cify)
UC.	5 0 0	lon:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injui	ay Year)	8b. Time of Injury		Injury Work			28d. Describe	now injur	y occurred	
Division of	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location City or To									ral Route Number,		
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical Co		/sician: To the best iner: On the basis of and manner si	of examination									
)	To the within 2 To the complet	Me	and marrier stated.							te signed (Month	n. Day, Year)			
	5		30. Name and address of person who d	completed cause of	death (Item 2	AR	· · 5017	pe -	307	~ e~	5 min	Ster	MD 2	1157
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Apr.	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last)	F	she	lps		2. Date of Dea Month	ath Day	Year Zoo7	3. Time of Death  3: 29 pm	
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number 3 oct 5. Homes 5. Social Security Number 6. Sex 1 M M 2 F		irthday)	Baltimo	r Location of Death  r C  If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug 15,	h v. Year)	9. Birthpla Count	ace (State or Foreign ry) unk	
	D.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	vn or Locat	tion		1106 13,		10	d. Inside City Limits	
	Maryl: a-f sho ified at	Director	MD Anne Arundel	Pasad	lena						1 ☐ Yes 2X No	
	ith the or 28: se not		10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Count	ry?	
	eath w is 23a must l	Funeral	8445 Fort Smallwood Rd.  11. Marital Status 12. Was Decede	ot Ever in II S	13 Wa	2112		ecify Vee or No.	USA 14 B	ace - America	n Indian	
920	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	δ	Armed Force  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ₽  If Yes, Give Year or Dates	s? ⊈No		es, specify Cuba Yes 215 No	Ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Spec	ack, White, e	etc.	
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Mary	12 shou h and M 7 Is mar traumat	-	19a. Informant's Name/Relationship (Type. Print) Mike Wombank/nephew	i	_	•	and Number or Rui				Code)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enonce.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta  4 Donation 5 Other (Specify) in stat	20b. Place o	of Dispositi	on (Name of tory or other place	. Glen Bu	Date		L n - City or Tov	wn, State	
Baltir			21. Signature of Funeral Service Licensee Anthony D. Pleasan	t H	Sta	lame and Addre	ss of Facility Omy Board MD 21201	l 655 W.	Balti	more S	treet	
>	Physician /Medical Examiner		23a. I ant. Enter the diseas of complications that caus shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death)  a. Due to (or a	ed the death. Do line.	not enter		ng, such as cardiac		rrest,		Approximate Interval Between Onset and Death	
68760,	tificate be executed g physician and as the burial-transit	cal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):									
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)  1 CertifyIng Physician: To the besigned manner	of examination a								
_	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sign	ned (Month, L	Day, Year)	
			30. Name and address of person who completed cause o	f death (Item 23a)	(Type Pri				04/2	1-1	, 2007	
			Bassel Alkhalil Harbor Hosp	strar's Signature	15.1	tanover	st B	altimo	re, M	0,2	1225	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regi	S. Signature	will							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 9869 7-25-07 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Rosa Pollard Year **Physician** 15, AM ROSM 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** RANDALLSTOWN NORTHWEST HOSPITAL arks)mont If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2√ F 91 Director 230-46-4160 4-26-1916 Va Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Md. Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 USA 5412 Old Court Rd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12th grade N.Y. System and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o any injury or other transmits. ould be f Mental I Robinson Gertrude Branch Edward ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1812 E. Federal St., Baltimore, Md. Helen Erby Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 7-20-07 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East lade waner 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERKALEMIA **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner FAILVA RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? 2 DONO Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 R/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1002497D s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add RANDALLSTOWN 5401 DLO COVAT RVAD FABER Day, Year) gistrar's Signature 31. Date filed (Month, 32 State 2007

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 21,22,per FH,0869, 7/25/07 TICertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician uknell Lee 200 ickey /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA Union memoria ( If Under If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, **Funeral** Days Min. Months Hours 1**№**M 2□F Yrs. **Director** 217.82-462 Usual Residence of Deced JAN. 11960 mi the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at mi Director 1 Tes 2 No BAH MOT 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Gth GRAde SALEMAN None 6-00d Will 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ille ပ mile 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Raral Route Number, City or Town, State, Zip Code) Shieleg BALTIMORE uRnell 2/202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Zion Cem. ands down M.D. 21. Signature of Funeral Service Licensee Lauret M. Thompson, 22. Name and Address of Facility March F.H. East 1101 E. North Ave. Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma /Medical Due to (or as a consequence of): Examiner inunite Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably nknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? Yes 2 No 2□ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes မှ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending 1 Natural To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 1 Tes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Ye

Memonol

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

		-	For State Of Ma	iryiana / Depa <i>Cei</i>	rtificate of I			eg. No.				
Į.			1. Decedent's Name (First, Middle, Last)			- :	2. Date of Deat Month		3. Time of Death			
18,5	Physicia Medic		Willard	Pa	ate			23 2007	0129 ™			
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of De				
1	26.7.1		Good Samaritan Hospital  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	imore  If Under 24 Hrs.   1	8. Date of Birth		NA irthplace (State or Foreign			
	Funeral Director		238–64–7551 1\(\frac{1}{\text{\text{\text{\M}}}\text{\text{\text{\M}}}\text{\tilie{\text{\texi}\text{\texi}\text{\text{\text{\text{\texi}\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\text{\texi}\text{\text{\texi}	66 Yrs.	Months Days	Hours Min.	(Month, Day, 2-4-1	Year) (	N.C.			
	ow other		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits				
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	or 28	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What (	Country?			
	ath w	la l	5002 Walther Ave.			1214		USA 14. Race - An	eorioen Indian			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 □ Never Married  1 □ Yes 2 □ Never Married  1 □ Yes 2 □ Never Married  1 □ Yes 2 □ Never Married  1 □ Yes 2 □ Never Married  1 □ Yes 2 □ Never Married  1 □ Yes 2 □ Never Married  1 □ Yes 2 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 3 □ Never Married  1 □ Yes 4 □ Never Married	lo	was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	lican, etc.)	Black, Wh				
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2	ithin 7 ne. nan "l	Completed	Elementary/Secondary (0-12) College (1-4or 5	life.	DO NOT use retired	tired) Co.						
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and	d be f ental k ced of	Be c	Wyatt	Pate		Olivia	, , , .	Gre	en			
Maryland	2 should be f n and Mental H Is marked of raumatic ever	<u>P</u>	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number	r, City or Town, State	, Zip Code)			
	1 and 2 Health a tem 27 is		Barbara Williams Pate W:			Ave., Balt	imore,	Md. 2121	4			
Baltimore,	Pages 1 annent of He		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place) em. Pk.	7-28-		20c. Location - City of Randallst				
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P.O. Box	death cert e attending d for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of o Month	delivery Day Year			
<u>ر</u> ت	w requires that the deben signed by the should be detached		Part II. Other significant conditions contributing to death be	ut not resulting in the u	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
rds	equires en sig ould be	ed b	DIABETES MELLITUS,	CONGEST	IVE HEX	4RT	1 <b>P</b> Ý	es 2□No 3□	Probably 4 Unknown			
Reco	e la has je 2	Completed by	DIABETES MELLITUS,  FAILURE, RENAL FA  VASCULAR DISEASE	ILURE, I	PERIP HER	ZAL	24a. Was a autop perfor	sy prior t med? death	autopsy findings available o completion of cause of ?			
ta		Be Co	25. Was case referred to medical		26. Place of Death			es 2 No				
>	nysici lis cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	ner: 4 Nursing Hom	ne 5 🗆 Resid	ence 6 □Other (S	pecify)					
Division or Vital Records,	Attending Physician: r death. ector: After this certifica by the funeral director, I		27. Manner of Death  1 ☑ Natural 5 □ Pending 2 □ Accident investigation	ry 28b. Time of Injury	of 28c. Injui Woi	ry at 2 rk?  Yes 2 □ No	8d. Describe h	ow injury occurred				
Divis	al or Atte after des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injuding, et	ury - At home, farm, st c. (Specify)	treet, factory, office	2	8f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)  1 □ Certifying Physician: To the best 2 □ Medical Examiner: On the basis of and manner sta	f examination and/or in								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. Licens		29d. Date signed (Mo						
			on Tran	to My	D4	40 480		July 24	2007			
	4		30. Name and address of person who completed cause of defeating the second seco	eath (Item 23a) (Type	, Print) 760 BA	40 480 2 BELAN LTIMONE	n Ros	2123	6			
	Sta Regist			ar's Signature								

ORIGINAL

DHMH 17 Rev 1/2001

## 07-05460 Irene Praglowski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ne Praglowski		State of Maryland / Departi	ment of F	Health and	Mental I	Hygiene	7	YOUT BUSIN
	R	For State Certification	ficate of D	Death		Reg. 2. Date of Death	No.	3. Time of Death
Physicia edical Examin	n/ 1	Decedent's Name (First, Middle,Last)  Irene M. Prag	lowski					1530 hrs
Za(Out Exami		Facility Name (if not institution, give street and number)     1039 Bristol Place		. City, Town, or L Baltimore	ocation of Dea		4c. County of D	A
["orol	5	Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24			Birthplace (State or preign Marca 1 and
Funeral Director	- 1	218 07 6204 1_M 2XF 87	Yrs.	Months Days	Hours. N	<sup>din.</sup> 07/03/1	920	Country Mary land
A	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	n		1100		10d. Inside City Limits
low any	.	ou. Didio	ltimore				er des	1 X Yes 2 No
aryland 8a-f sh	$\sim$ 1	i 0e. Street and Number	3/4	10f. Zip Code		10g	. Citizen of What	
5-0036 Led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.		1039 Bristol Place	[40, 10]	21226		( Specify Yes or No-		merican Indian, Black,
th with	= 1	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 4 Armed Forces? 1 Yes 2 X No	If Yes	s, specify Cuban	, Mexican, Pue	erto Rican, etc.)	White, .e	
fler de:		3 X Widowed 4 Divorced If Yes, Give Year		Yes 2 X No			Specify: 16b. Kind of Busin	White
ours a	ed by	15. Decedent's Education (Specify city) mg. 124 g	16a. Decedent's during mos	s Usual Occupat st of working life	ion (Give kind DO NOT use	OI WOIN GOILD	- 4-	
36 in 72 h han "r	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 8th	Hom	emaker				Home
21215-0036 Muld be filed within 72 hours after Muntal Hygiene marked other than "natural"; event, the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)				ame (First, Middle, Ma		
21215 uld be file Mental H marked c event, t	a	Luther Walston	10h Mailing	Address (Stree		argaret Rit	er, City or Town,	State, Zip Code)
MD 21 d 2 should lth and Me n 27 is ma	٩	19a. informant's Name/Relationship (Type, Print) Wesley Walston / Brother	166 St	heffield	l G	West Palm	Beach,	Florida 3341/
	+		ace of Disposit	tion (Name of ce	I .	ļ		ity or Town, State
<b>5</b> 8 5 7 2 1			yview C	remator				ore, Maryland
Baltimore, permit. Pages lan Department of He Important: If ite		21. Strike re of Fun tral Porvice Licensee		ame and Addres	s of Facility hie Hio	Gonce Fund	eral Ser timore.	vice, P.A. Maryland 21225
Physician	-	3a. Part - Enter the disease or complications that caused the death. I	Do not enter th	ne mode of dying	, such as cardi	iac or respiratory arre	st, shock, or hear	Approximate Interval Between Onset and
/M dical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiova						Death
xaminer		or condition resulting in death)  Due to (or as a consequence of)	):					
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of)	):					
	Examin	cause. Enter Underlying Cause (Disease or Injury that initiated eyents resulting in death). Last	):					
e executed sian and ial – transit		dd.					<del></del>	
be exection a sician a	dica	UNPENDED AMENDED					23d. Date of o	delivery
lox 68760, leath certificate be attending physici for use as the buri	ician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the		etal death 3	Ectopic p	regnancy	Month	Day Year
Ox 68 eath cert e attendir for use a	sicia	past 12 months?  1  Yes 2 ✓ No 9 Unknown g Unknown	ath 5 Ot	ther (Specify)		-		
). BC the dear by the a	Physi	Part II. Other significant conditions contributing to death but not re	esulting in the u	underlying cause	given in Part			oute to the cause of death?
cords, P.O. B aw requires that the d has been signed by the 2 should be detached	β							Probably 4 Unknown  Vere autopsy findings available
rds, requir	Completed					24a. Was autop	sv p	rior to completion of cause of eath?
Recol The law cate has	mo:					1 Yes	2 <b>V</b> No 1	Yes 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient		Tour .	Nursing Home 5	Residence 6	Other: Scene
n of Viting Physical After this funeral dir	<u>د</u>	1 ✓ Yes 2 No Impaired  27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of		jury at Work?	28d. Describe	how injury occurre	ed
ion C tending eath. tor: Af the fun	tio	1 V Natural 5 Pending			Yes 2 N		Ol and and Niversity	er or Rural Route Number, City
ivisi or Att after de Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At he	ome, farm, stre	eet, factory, office	e building, etc.	or Town, S	State)	3 Of Raid Route Hamber, Only
Ospital hours uneral v fillec		4 Homicide	ige, death occu	urred at the time,	date and plac	e, and due to the cau	se(s) and manner	as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici or on the Funeral Carefor is the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the test of my knowled one)  2 Medical Examiner on the basis of examination a anomarmer stated.	and/or investiga	ation, in my opini	on, death occi	urred at the time, date	and place, and d	ue to the cause(s) ed (Month, Day, Year)
P F F S	Me	29b. Signature and title of certifier			ense number C.M.E.		July 17, 20	
0		( MmL	n 23a1		J.1V1. L.			
D		30. Name and address of person who completed cause of death (Item David Fowler M.D. Chief Medical Examiner	111 Penn S	Street, Baltin	nore, MD 2	1201		
		24 Date filed (Month Day Your) 32 Registar's Signat	ture .	8 4				

Registrar

			For State	State of Ma	-	artment of I rtificate of		Mental Hygiei Reg.		111504				
			Registrar  1. Decedent's Name (First, Middle, Lat	st)		imodio oi	Dout.	2. Date of Death	Te 24 / "	3. Time of Death				
Н	Physici			Joseph B	ratten Rog	iers			Day Year v 22, 2007	5:30 a <sup>M</sup>				
e h	/Medio		4a. Facility Name (If not institution, give		ration itog		or Location of Deatl	n	4c. County of Death					
		13	N	laryland Mason	ic Home			ockeysville		Baltimore				
١	Funeral Director			ex M 2□F 7. Age	(In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye September	ear) Cou	place (State or Foreign intry) Maryland				
	and ww		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits				
	Maryli f sho ied al	ţ	Maryland	Baltimore			Cockeysville			1 □Yes 2 No				
	r 28a	Director	10e. Street and Number			10f. Zip Code		_	Citizen of What Cou	•				
	th with		300 International C	ircle			21030	)	U	J.S.A.				
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 2□ Married	12. Was Decedent E Armed Forces? 1 M Yes 2 □ N If Yes, Give	0	Was Decedent of If Yes, specify Cut  1 ☐ Yes 2 No	Hispanic Origin? (S pan, Mexican, Puer Specify:	pecify Yes or No- to Ricen, etc.)	14. Race - Ameri Black, White					
21215-0036	ural",	d by	3 ☐ Widowed 4 Divorced	Year or Dates:	1945				Specify:	White				
5	"natu edica	lete	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	rking 16b	. Kind of Business/Ir	ndustry				
12	withir iene. than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		surance ager	nt	Ins	surance				
9	other ent, 1	Be C	17. Father's Name (First, Middle, Last,	)			18. Mother's Nar	ne (First, Middle, Mai	den Surname)					
Maryland	ould be I Menta narked natic ev	To E		b D. Rogers					beth Bratten					
	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship ( Ms. Betsy Rogers F	**	aughter			ural Route Number, Ci t Pikesville, Ma		ip Code)				
altimore,	8 = 0		20a. Method of Disposition  ↑ Bunal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)	metery	07/25/07	: Location - City or T Ellicot	own, State tt City, MD						
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer	a Broke	ess of Facility ck Funeral Ho 1 Old Columb	ome, P.A. Dia Pike Ellicott	City. MD 2104	43						
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent	er the mode of dy	ing such as cardia	c or respiratory arrest		Approximate Interval Between				
1	Physician		Immediate Cause (Final disease or condition	a Cere	hwvaod	inlar D	usease			Onset and Death				
	/Medical Examiner		resulting in death)	Due to (or as a	e.  Low Co C  consequence of):  consequence of):	1/0	2 1	\						
		-e	Sequentially list conditions, if any leading to immediate	b. Due to (or as a	consequence of):	n. Vasc	uler fi	sere						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	icate be executed physician and the burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence of):			*·····		-				
8760,	cate be	dical	•	d										
Division or Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome particles to the second of the secon	2 ☐ Fetal death 3 ☐	⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	су		23d. Date of deliv Month	very Day Year				
о <u>.</u>	uires that i signed by d be deta	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?				
rds	w requires been sign should be		Hyporteusin,	Cornay C	artey D	seare,	S/P CVY	1 □ Yes	2 No 3 Pro	obably 4 Unknown				
Reco	s <b>ician:</b> The law requicetrificate has been rector, page 2 should	Completed	Areria,	-				24a. Was an autopsy performed	prior to co	topsy findings available ompletion of cause of				
/ita	clan: ertifica	Be C	25. Was case referred to medical examiner?			ath (Check only one)								
2	Physic this c	၉	1 ☐ Yes 2D No 27. Manner of Death	Hospital: 1 ☐ Inpatie		IL 3 DOA		fome 5 Residence		ify)				
ono	ding I After funer	tion:	1 Natural 5 ☐ Pending	(Month, Day		Wo	ork? ]Yes 2∐No	28d. Describe how i	injury occurred					
ivisi)	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e Place of inju	ry - At home, farm, str . (Specify)			28f. Location (Stree City or Town, S	t and Number or Ru	ral Route Number,				
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce		nysician: To the best of miner: On the basis of and manner sta	examination and/or in									
	To the Vithin To the complete	Me	29b. Signature and title of certifier			29c. Licen	se number	29d.	Date signed (Month	n, Day, Year)				
			P.T. Filest	5, m.		Di	21464	'	7/23/67					
ĺ	2		30. Name and address of person who ROBERT LIBERT	completed cause of de	eath (Item 23a) (Type,	Print)	Mare	21224	/					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ROBERT LIBERT WW. 3508 Bank St. Ballo, Null 21024  State Registrar  31. Date filed (Month, Day, Year)  JUL 25 2007									·					
					9									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 19:50PM Dorothy Lanson 200 ulu 6 /Medical 4c. County of Death 4a. Facility Name (If ried institution, give street and number) 4h City Town or Location of Death Baltimore Uty
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Y.

5-20-Examiner Bayview Medical Center

6. Sex 7. Age (In yrs. last birthday) Johns Hopkins 9. Birthplace (State or Foreign Sountry) 5. Social Security Number 7. Age (In yrs. last birthday)
Yrs. **Funeral** 218-22-7679 1 □ M 2 🔀 F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **e**how 7 is marked other than "natural", or iteme 23a or 28a-1 shov treumatic event, tre Medical Examinar must be notified at 1 Yes No Funeral Director unda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 ISA 200 Walnut Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■No Specify: Specify. Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementa (0-12) Cotlege (1-4or 5+) omestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Pages 1 and 2 should be fit iment of Health and Mental Hisant: If Item 27 is marked other. Be 19a. Informant's Name/Relationship (Type, Prot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Walnut Avenue Durdalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removat from State ö Department of Important: If any injury or once. 124/07 Owings Mills. MI 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Oit 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial Immediate Cause (Final Infarction **Physician** hour disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown sete has been signed by a page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete To the Hospital or Attending Physician: After this certification, I Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 1 Inpatient Certification; To 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturat 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation the Director: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hkwaa, Medical Doctor Res-000 2007

State Registrar

10

DHMH 17 Rev 1/2001

medi

Bayview, 4940 Eastern

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins

Registrar's Signature

Akwaa

25

2007

31. Date filed (Month, Day, Year)

Baltimore

Avenue Maryland 21224

				1 - For State Registrar	State of Maryl	and / Depa		of H		_			20001
	Dh	and the		1. Decedent's Name (First, Middle, La	ist)					2. Date of De	aath Day	Year	3. Time of Death
		ysicia Medic		Shirley C. Role						Ju1y	24, 20	07	5:20 A M
	Ex	amin	er	4a. Facility Name (If not institution, give			4b. City, T		Location of Deat	h		nty of Death	
	Fun	eral		Atlantic General 5. Social Security Number 6.5		yrs. last birthday)	If Under 1	Year	lin If Under 24 Hrs.	8. Date of Bir		ceste1	place (State or Foreign
	Dire			212-32-7461	1□M 2 <b>X</b> F	71 Yrs.	Months	Days	Hours Min.	7/14	/36		intry) y land
	and			Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	ocation					<u>-</u>	10d. Inside City Limits
	Manyi -f eho	fleds	ţ	MD Worces	ster		1	Ber1	in				1 ☐ Yes 2 🔀 No
	death with the Maryland ms 23a or 28a-f show	Tou a	Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip 0				10g. Citizen	of What Cou	ıntry?
	ath wi	ust b	rai	9213 Seahawk Roa				218				USA	
1	ter de	Dar	Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No	in U.S. 13.	Was Decede If Yes, specif	int of Hi fy Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No to Rican, etc.)	)- 14. F	Race - Amer Black, White	
300	5-UU35 72 hours after natural', or ite	Exam	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No	Specify:		Spe	cify:	White
6 4	<b>5-0</b> 72 ho	dicat	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual	Occupa	ation furing most of wor	rking	16b. Kind o	f Business/li	ndustry
1/2	within 500.	a Ma	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life.						Home	
7 %	should be filed within Mental Hygiene.  marked other than	aut, tre	Be Completed by	17. Father's Name (First, Middle, Las	0		Home	amar	18. Mother's Nar	ne (First, Middle	1		
	VIA De VII De Aental	tic ev	To B	Earl C. Bradley	,				Clara	a Bell H	andle		
, ,		aume.		19a. Informant's Name/Relationship					and Number or Ru				
00	ore, M as 1 and 2 of Health of litem 27 i	ther tr		Mr. leroy J. Role 20a. Method of Disposition		9213 b. Place of Dispo	Seahav		Road Be	erlin, M	arylan 20c. Locatio		
000	Pages Tent of Part of	or of		1 SBurial 2 ☐ Cremation 3	Removal from State	cemetery, cre	matory or oth	er plac				·	
-	altimore, rmit. Pages 1 ar partment of Hea portent: if item:	inlur)	i	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	)114	oudon Pa	rk Cen 2. Name and	nete Addres	ery 1 7/2	27/07	Balti	more,	Maryland
Ċ	D gg ii	any ii		Eugene \	(00	. 17			ns Ave.				
				23a. Part1. Enter the disease, or conshock, or heart failure. List	plications that caused the cone cause on each line.								Approximate Interval Between
	Physic	_		Immediate Cause (Final disease or condition	a. Cerebrova	scular	accid	den	+				Onset and Death
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			ē	Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	зыциетсь об).		-					
1461	cuted	ransit	Examiner	that initiated events	C								
7 5	/ <b>bU,</b> te be exe ysician al			resulting in death) Last	Due to (or as a con	sequence of):							
	<b>557</b> tiflicate b	as the b	dicai		d							+	
33	BOX 68 eath certifical	usea	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre						23d.	Date of deliv	very
	I HECOIDS, P.O. BOX DE The law requires that the death certifical ale has been signed by the ettending phy	should be detached for use	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		⊒Ectopic pre ☐ Other (spe					Month	Day Year
22	d by th	etach	Phy	9 🗆 Unknown					- in Donat	aza Did			the serves of death?
_ 1	dS, F ires tha signed	p eq p	b b	Part II. Other significant conditions Severe Chronic old		_	inderlying cal	use give	en in Parti.		Yes 2 No		the cause of death?
Je.	COL W requ	shoul	etec	BOVO C GIVATE OF	SITUALITY PRINT	J	VINUM	36		24a. Was			opsy findings available
Roles	VICIAN ME VICIAN: The lay Certificete has	age 2	шо							auto	psy ormed?	prior to o death?	ompletion of cause of
> !	Ital ian: ian: rtifice	otor, p	BeC	25. Was case referred to medical		-			26. Place of Dea	1 ☐ Yes ath (Check only)		I LI TUS	2 No
7	OT VITA Physician: this certific	il direc	၉	examiner? 1 Yes 2 No	Hospital: Inpatient	2 ER/Outpatier			4 U Nursing F	lome 5 ☐ Res	idence 6 🗆	Other (Spec	ufy)
Shirley	Jing P	funera	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	of 28	c. Injun	/ at ⟨? Yes 2 □ No	28d. Describe	how injury oc	curred	
01 1	UIVISION OT VITAI HECOTAS, for Attending Physician: The law requires taller death.  Director: After this certificate has been signe	y the	Certification:	2 Accident investigation 3 Suicide 6 Could not to	De Place of Injury	At home, farm, st			765 2 140	28f. Location (	Street and Nu	ımber or Ru	ral Route Number,
ä	S affer	u pe	Cert	4 Homicide	building, etc. (Sp	pecify)				City or To	wn, State)		
	DIVISION  To the Hospitel or Attendit within 24 hours after death.  To the Funeral Director: A	completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) Certifying P	hysician: To the best of my miner: On the basis of exar and manner stated.	knowledge, deat mination and/or in	h occurred a vestigation, i	t the tim	ne, date and place pinion, death occu	a, and due to the urred at the time,	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)
	To th Withir	comp	W	29b. Signature and title of certifier	1		29c.	License	number .		29d. Date sig	ned (Month	, Day, Year)
				Uf van Eg	amond M	D	T	000	54307	۷ ,	July	24, 2	1007
	13			30. Name and address of person ying	completed cause of death	(Item 23a) (Type,	Print)	7	56307 Erlin, Mc	71611			
		Stat	te.	J. vou Egmond A 31. Date filed (Mooth, Day, Year)	1D, 9733 Hea 32. Registrar's S	ignaturo . I			rin, im	/ ×   8			
	Re	gistra		JUL 2 5		1 15 1	peri						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Dorothy M. Radziszewski 9:30 AM 2007 July/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Laurel Health & Rehab. Prince Georges Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 KF 214 14 9298 84 **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23e or 28e-f show treumatic event. The Medical Examinar must be notified at 1 Yes 2 No Maryland Howard Columbia Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6044 Tree Swallow Court U.S.A. 21044 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 9th Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked othe any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Umboski Cecilia (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Radziszewski / son 6044 Tree Swallow Court Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7/24/2007 Baltimore, Maryland 21. Signalur A Funer A Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Fart1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Eist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) 2-3DA45 /Medical Examiner PNEUMONIA 4SPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physiclan/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, COPN 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel C 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier ATTENDIN G 29c. License number 2005 カイイフノロイナの 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. BRAILD M.D. 34-50 FT MEASE 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/200

			1- State of Maryland / Depa Cer	tificate of Death	Mental Hy	/giene Reg. No. 2	7 2300
Ľ	Physic		1. Decedent's Name (First, Middle, Last)  Dorothy A. Richards		2. Date of Do	eath 24 2007	3. Time of Death 2:30 a M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Dea	ath
_	Funcial		Gilchrist  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson  If Under 1 Year   If Under 24 Hrs	8. Date of Bi	Baltimo	
ŀ	Funeral Director		220-09-5312 1 M 2X F 89 Yrs.	Months Days Hours Min.	Sept 1	ay, Year) C	rthplace <i>(State or Foreign</i> o <i>untry)</i> a <b>ry l and</b>
	aryland show	_	10a. State 10b. County 10c. City, Town or Loc				10d. Inside City Limits
	the Ma 28a-f	Director	Md. Baltimore Baltimor				1 ☐ Yes 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	al Dii	901 Cold Spring Road	10f. Zip Code 21220		10g. Citizen of What C	
	ter dea items	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	pecify Yes or No to Rican, etc.)	o- 14. Race - Ame Black, Whi	
920	ours af rai", or Exami	l by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ X No If Yes, Give 1  X Widowed 4 □ Divorced Year or Dates: 1	☐ Yes 2 💢 No Specify:		Specify: Wh	nite
15-0	n 72 h "natu edical	Completed by Funeral	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of wo O NOT use retired)	king	16b. Kind of Business	/Industry
212	filed within Hygiene. ther than "	Somp		maker		Own Hon	ne
Maryland 21215-0036	l be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)			, Maiden Surname)	
aryk	should ind Men imarke	은	Charles H. Arnold II  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing	Address (Street and Number or Re		leathersteir per. City or Town, State	
	1 and 2 Health a tem 27 is		Mr. Charles Arnold III/ Brother 901	Cold Spring Rd.			
Baltimore,	Pages 1 nent of H ant: if ite ury or otl		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, cremetery, cremeters, c		Date	20c. Location - City or	ŕ
altir	permit. P Departme Importan any injury			ge Cemetery 7-20 Name and Address of Facility Ruck Towson Full Ruck Towson Full		Pikesville	e, mu.
<u> </u>	on a m			1050 fork ka.	lowson.	Ma. 21204	
	Physician		23a. Part1. Ent if the disease, of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	11			years
	Examiner	į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b.   Due to (or as a consequence of):				
	cuted nd ransit	Examiner	that initiated events				
60,	be exercian ar		resulting in death) Last  Due to (or as a consequence of):				
68760,	tificate be executed ig physician and as the burial-transit	edical	d				
Box	ath cert ttendin or use	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	Ectopic pregnancy		23d. Date of de	
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/N	1 ☐ Yes 2 A No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month	Day Year
Records, P.O	res that igned to be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the unc	ferlying cause given in Part I.		obacco use contribute to	
2000	w requi	Completed			10		robably 4 Unknown
	as a	omo				psy prior to death?	utopsy findings available completion of cause of
Vita	sician: The certificate hi	BeC	25. Was case referred to medical examiner?  157. Value (158. No. 159. No. 1	26. Place of Dea	1  Yes th (Check only o	2 to No 1 □ Yes	2 No
	this al di	-1. -1.	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA Other: 4 Nursing H	ome 5 Resident	dence 6 Other (Spe	city) huspice
Sion	Attending I death. ctor: After y the funer	ation	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	Work?  M 1 ☐ Yes 2 ☐ No		,,,	
Division or	l or At after d Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined	et, factory, office	28f. Location (\$ City or Tox	Street and Number or Ru vn, State)	ural Route Number,
			29a. Certifier (Check only one)  29a Certifying Physician: To the best of my knowledge, death of the control of the pass of examination and/or investigation.	occurred at the time, date and place	, and due to the	cause(s) and manner as	s stated.
	o the hithin 24 o the F	Medical	and manner stated.  29b. Signature and fille of certifier	29c. License number	ned at the time,	29d Date signed (Mont	b Day Yaar
)	0		· Olivery	D 5830	3	July 24	2-007
5			29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Pr  31. Date filed (Month, Day, Year)  32. Registrar's Signature	IN Charles	St 70	ason no	21204
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	berli		Al	

Conrac Ivan Strange 07-05406 Please UNK UNK

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State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar Certificate of Death  Physician/  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death													91			
Physicia			le,Last)	-		noute of				2.			L w		. Time of Death	ar .
edical Exami		CONRAD IVAN SI									Month July 15, 2	Day 2007	Year		0449 hrs	
		4a. Facility Name (if not institution		number)		4t	c. City, To	wn, or Lo	ocation of I		00,7 10,2		County of	Death		
		Johns Hopkins Hospit	tal				Baltimo	ore				4				
Funeral		5. Social Security Number	6. Sex	7. Age (I	In yrs. last	t birthday)	If Under	1 Year	If Under 2	24Hrs.	8. Date of B	irth(MM/D	D/YYYY)	9. Birth	olace (State or	
Director		210 02 2754	1X M 2	_	25	Yrs.	Months	Days	Hours	Min.	NICK 7	20 1		Foreign Coun	try) MD	
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rylan a-fsi	cto	MD 10e. Street and Number			DAL	TIMORE	10f. Zip C	ode		_		10a. Citize	en of What	Countr	v?	
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r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral			Forces?					Mexican, P				White,		· ·	
after death with the Maryland ral", or Items 23a or 28a-f sho iner must be notified at once			orced If Yes, Give		No		Yes 2 🗙	No	snecifu:				Specify:	RT.AC	rK	
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d with	15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind and the property of the property o									Name (F	irst, Middle,			THI	LV	
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e, land Healt item	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,										Date	20c. Lo	ocation - C	ity or To	own, State	
DOF In tof I other	3 Widowed 4 Divorced If Yes, Give Year or Dates To Dates The Broad of Divorced If Yes, Give Year or Dates To Dates The Broad of Divorced If Yes, Give Year or Dates To Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad of Divorced If Yes, Give Year or Dates To Date The Broad Of Divorced If Yes, Give Year or Dates The Broad of Divorced If Yes, Give Year or Dates To Date The Broad Of Divorced If Yes, Give Year or Dates The Broad Of Dates The Broad Of Dates The Broad Of Divorced In Park of Dates The Broad Of Dates The Broad Of Dates The Broad Of Dates The Broad Of Dates The Broad Of Dates The Broad Of Dates The Broad Of Dates The Bro								- /-	. /				HILL RD	).	
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/Medical		failure. List only one cause	on each line.					-jg,					., ,		Between Onset Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)		Gunshot \ is a consequ		S								-	Death	
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Box 6876( re death certificate the attending physical for use as the b	Ž	IF FEMALE: 23b. Was decedent pregnant in ti	ho —	es, outcome	of pregna			2	T-4				Date of de		Vaas	
certi	Physician/M	past 12 months?	1 [ 10	e birth egnant at tim	ne of deat	_ =	al death er <i>(Specif</i>	3	Ectopic p	regnanc	уу	1 '	Month	Da	y Year	
30x death le atte	ysi	1 Yes 2 No 9 Un	known	known		J Otne	er (Specii	у/								
D. E		Part II. Other significant condit	tions contributin	g to death bi	ut not res	ulting in the un	derlying c	ause giv	en in Part	1.	23e. Did	tobacco u	se contribu	ute to th	e cause of death	?
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hysi	examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other; 4   Nursing Home 5   Residence 6   Other:															
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Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical		miner:On the bas and manne		ation and	or investigation				irred at ti	ne time, date					
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		hing	as,	no	$\triangleright$		(	O.C.M	.E.			July	15, 200	7		
/ A		30. Name and address of person	who completed o	ause of deat	th (Item 2	3a)						1			<del></del>	
30		Ling Li, MD Assista	nt Medical Ex	caminer	111 P	enn Street	, Baltim	ore, M	D 2120	1						
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07-05500 Daniel Santiago

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illei Saittago		1- For State Certificate of Death	Reg. No	o	
Physici		1. Decedent's Name (First, Middle,Last)	ate of Death onth Day	Year	3. Time of Death 2345 hrs
edical Exam		DANTEL LUIS SANTIAGO	ly 17, 2007	c. County of Deat	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Leatin	ľ	tc. County or Deat	"
		Johns Hopkins Bayview Medical Center Baltimore	Date of Birth (MA)	W/DD/YYYY) 9. Bi	rthplace (State or
Funeral		5. Social Security Number 6. Sex Min.		Fore	gn
Director		213-92-4368   1X M 2 F   29 Yrs.   F1	EB. 21,	1978 <sup>c</sup>	ountry) MD
		Usual Residence of Decedent			10d. Inside City Limits
any		10a. State 10b. County 10c. City, Town or Location			1 X Yes 2 No
/land -f show	5	BALTIMORE	1400 0	Citizen of What Co	untry?
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	109. 0		unay.
the N a or	吉	6302 FORTVIEW WAY 21224		USA	erican Indian, Black,
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5-00 led withi Hygiene other th	6	7TH DISADITED  17. Father's Name (First, Middle, Last) UNK  18. Mother's Name (First, Middle, Last)	st, Middle, Maid	en Surname)	
1215-0036 Id be filed within 72 Aental Hygiene. narked other than "	e O	bl RUTH SANT	rana		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she wite event, the Medical Examiner must be notified at once	O B	19a. Informant's Name/Relationship (Type, Print )			ate, Zip Code)
and 2 shoul lealth and N tem 27 is in	-	LUIS SANTIAGO 301 S. ANN ST., BALTIM	ORE, MD	21231	Town State
e, MD 1 and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of Certifier,	ate 20	5712 O D	or Town, State ST.
imore Pages 1 ment of F tant: If i		1 X Burial 2 Cremation 3 Removal from State MTL CARMET.	5-07	BALTIMOR	E, MD 21224
Baltimore, permit. Pages la Department of He Important. If its injury er ofther it	5	21 Signature of Funeral Service Licensee 2	EY CHAV	IS, JR.	FNRL. HM.
Ba Perm Dep		2007-09 FASTERN AVI	E., BAL	TIMORE, I	MD 21231 Approximate Interval
Physicia	n	23a Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or resfailure. List only one cause on each line.	spiratory arrest,	shock, or heart	Between Onset and Death
Wedica	-	Immediate Cause (Final disease a. Gunshot wound of Neck			Deatil
.amine		or condition resulting in death)  Due to (or as a consequence of):			
	١.	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):			
	<u> </u>	cause Enter United James C.			
11-	<u> </u>	if any, leading to immediate cause. First fundarlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):  d.			
Records, P.O. Box 68760, ————————————————————————————————————	trani	d.			
760, cate be exe	le burial	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	very
76( icate			у	Month	Day Year
68 certif	ise as	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		ļ.	Į.
Box 687 The death certification in the attending p	for	2 Petal death past 12 months?  1 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Lan Billion		e to the cause of death?
at the	tache				Probably 4 V Unknown
P. es tha	pe de	py and a py			e autopsy findings available
ds, requir	plnor		24a. Was an autopsy	prior	r to completion of cause of
COI e law	e 2 sl	26.Place of Death (Check onl	perform 1 <b>Y</b> Yes 2		Yes 2 No
Re The	r, pag		ly one)		
ital iician s cert	irecto	m examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4 Nursing I	Home 5 R	esidence 6 0	Other:
Division of Vital Records, P.O. B rat or Attending Physician: The law requires that the d and red and requires that the d and recent that this certificate has been signed by the	eral d	27 Manner of Death 288, Date of Injury 200, Time of Injury	8d. Describe ho ubject shot	w injury occurred	
nding T. Af	fun .	Jul 17, 2007 Pending Jul 17, 2007 2308 hrs 1 Yes 2 ✓ No	•		
isic Atte er dez irecto	by tl	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 26e.	28f. Location (Story or Town, Sta	reet and Number ( ate) Way, Baltimore,	or Rural Route Number, City
Div	lled in	6 4 Homicide			
Hosp 24 hot Fune	tely fi		lue to the cause the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death.	omple	and manner stated.	1		(Month, Day, Year)
A F 3 F	Ü	29b. Signature and title of certifier  OCME  O.C.M.E.		July 18, 2007	
		Leodore M. G. F. J. J. L. L. D.			
2	ĺ	30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King Jr. MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	. MD 21201		
3		Theodore W. Tang, St., W.E. Tastetta			
D-	Sta gisti	ate 5 2007 Market 1			
142		JUL N V			

			For State	State of Marylan	d / Depa	artme	nt of Health ar		•		gibic.	930	111
			Registrar		Ce	rtifica	te of Death			No.	'w w' b		
	Physici	an	Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time o	of Death
	/Media		Robert Frank		ec				july 19	_	2007	2:50	М
	Examir	er	4a. Facility Name (If not institution, give s				Town, or Location of				unty of Death		
			14900 Eastway I 5. Social Security Number 6. Sex		last hirthday)		Silver Spar		Date of Birth		ontgo!		or Foreign
	Funeral Director			(M 20 F 69	Yrs.			Min.	Date of Birth (Month, Day, )	(ear)	7 Cour	lace (State itry)	Ji Füleigii
	D .		Usual Residence of Decedent  10a. State 10b. County	100 0	Town and							04 1	Sh. I Sasta
	anyla •hov	-			y, Town or Lo						[ ]	0d. Inside 0	287No
	28a-f	Director	Maryland Montgo	mery	71		Spring		1.0	0	-(110-1-0		2-4
	with a or 3		14900 Eastway	Daire		101. 2	20905		100	g. Citizen	of What Cour	itr <b>y</b> r	
	Jeath Ins 23	Funerai		12. Was Decedent Ever in U	.S. 13.	Was Deci		n? (Specify	Yes or No-	14.	Race - Americ	an Indian,	
CO.	or Hear		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑No			edent of Hispanic Origin ecify Cuban, Mexican, I	Puerto Rica	an, etc.)		Black, White,		
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Menial Hygiene.  marked other then "neturel", or items 23a or 28a-f ehow marke other then "neturel", or items 23a or 28a-f ehow marke event, the Medical Examinar marke notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2. No Specify:			Sp	ecify: Wh	ite	
ည	72 h	etec	15. Decedent's Educ (Specify only highest grade		(Give	kind of w	ial Occupation ork done during most o	of working	16	6b. Kind	of Business/Inc	dustry	
2	vithin nen hen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.		ise retired)			P -	nedelin		
N	Hygie ther t nt, th	ပိ	17. Father's Name (First, Middle, Last)	5+		٠,	ntractor 18 Mothers	s Name /Fi	rst. Middle, Ma			9	
ali	ot be	Be C	Robert G.	Salaudae			TO. WOLLOW	Luci		ock			
2	should and Men marke umatic	ဥ	19a. Informant's Name/Relationship (Type		19b Mailir	na Addres	s (Street and Number					Code)	
Š	12 har		Jeanette Schuder			-			er Sprin	-			
Baltimore,	permit. Pages 1 and 3 Depertment of Health Important: If Item 27 eny injury or other tri once.		20a. Method of Disposition	20b. F	lace of Dispo	sition (Na	me of	Date			ion - City or To		
Ē	Page lent of nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other (Specify)				Registry Jul	14 20,	2007 +	tan	OVEF	MA	
alti	porta porta y inju		21. Signature of Joneral Service License		22	2. Name a	nd Address of acility	Anat	omu Git	ets R	Registry		
m	88 E 8 8				75	32ZC	nd Address of acility onnelley Dr	ive su	ite P. H	lanov	ier, MD	210	76
п			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not ent	ler the mo	de of dying, such as ca	ardiac or re	spiratory arres	t,		Approxima Interval Be	tween
)	Physician		Immediate Cause (Final disease or condition	Colon	Cance	-						Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq									
	Lxammer	_	Sequentially list conditions,										
	ed skt	lue	Sequentially list conditions, if any, leading to immediate cause. Enior Underlying Cause (Disease or injury	Due to (or as a conseq	uence ot):								
	xecul and ai-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								_
/60,	eath certificate be executed ettending physicien and for use as the burial-transit	calE									- 6		
			0										
Вох	nding use a	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna						23d	. Date of delive	iry	
Ď.	death e ette id for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta		□Ectopic p □ Other (s	regnancy pecify)				Month	Day	Year
o.	at the de by the ortached	hys	9 Unknown	9□ Unknown									
S,	ss tha	by Physician/Med	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying	cause given in Part I.				contribute to the		
Records,	w require been signshould b	ted						[	1 🗆 Yes	2 🗆 N	lo 3 ☐ Prob	ably 4_2	Unknown
ပို	law ras be	ple							24a. Was an autopsy	2	4b. Were auto	psy findings	available cause of
	W L4	Completed							performe	No No	death? 1 ☐ Yes	25 No	
Vital	Physician: The law this certificete has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	4-1				f Death (C	heck only one)				
_	A .= 0	2	1 1 162 2 12 140	ospital:					5XResiden			1)	
ח	Jing I	io	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	1	Describe how	injury oc	curred		
<u>s</u>	death death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm str				Location (Stre	et and N	umber or Rura	l Route Nur	pher
Division of	he Hospital or Attending Ph in 24 hours after death. he Funerel Director: After th pletely filled in by the funeral	Certification:	4 Homicide determined	building, etc. (Specif	/)	eet, racto	y, omoe	201.	City or Town,		amour or rigin	r riodio redi	1001,
	pspita hours unerel y fille		29a. Certifier 1 Certifying Phys	icien: To the best of my kno	wledge, death	h occurred	at the time, date and	place, and	due to the cau	se(s) and	d manner as st	ated.	
	he Ho in 24 he Fu pletel	Medicai	(Check only 2 Medical Exeminate)	er: On the basis of examina and manner stated.	tion and/or in	vestigation	i, in my opinion, death	occurred a	it the time, date	and pla	ce, and due to	the cause(	5)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	•	1		c. License number		1		gned (Month,	ni uli	
			, - 17-7	M	<u>い</u>		035635			Jule	1 20	200	7
			30. Name and address of person we co										
			Joseph Kaplan, M. 31. Date filed (Month, Day, Year)	32 Registrar's Signa	Tura	nce P	hilip Drive	•	olney.	MD	2033	2	
	Sta Registr	_	JUL 2 5 20	07 August 1	Ji do	BARL .	•						

		•	For State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygier	2007 20007
	Physici	20	Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physici /Medic	al	Queene	SmITIT	die Oile Tour and audion of Dan	July 2	22 2007 11.30 AM
	Examin	er	4a. Facility Name (If not institution, give	Coans ra	4b. City, Town, or Location of Dea		Howard
	Funeral Director		5. Social Security Number 6. Sec. 2/3-32-6661	7. Age (In yrs. last birthda	Months Davs Hours Min		9 Birtholage (State or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Maryl	tor	Md Howar	d Colu	mbia		1 ☐ Yes 2 ☐ Ho
	with the	Director	10e. Street and Number 6648 Meadew R	0 /	10f. Zip Code 210 75	10g.	Citizen of What Country?
	death	Funeral	11. Marital Status		Was Decedent of Hispanic Origin? (     If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
920	within 72 hours after death with the Maryland ene. then "netural", or llems 23e or 28a-f show the Madical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Affiled Forces?  1 Yes 2 Mo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	no rican, etc.)	Specify: Black
15-0	d within 72 hours jiene. r then "netural", I'ne Wedical Ex-	letec	15. Decedent's Edu (Specify only highest grad	lication 16a. De (Gi (Gi (ifit	cedent's Usual Occupation ive kind of work done during most of work one during most of work of DO NO was retired)	orking 16b	Kind of Business/Industry
212	77 75	Completed	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	Demistic		Domestic
Maryland 21215-0036	d tal	To Be C	17. Father's Name (First, Middle, Last) Richard Wilson	Se.	18. Mother's Na ISab	el Wansin	len Sumame) 2
Mary	2 should and Men is marke		19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Ma	ailing Address (Street and Number or F		
	Health Health Iem 27 other tre		20a. Method of Disposition	20b. Place of Dis	f8 / ROCKW Kidge	Date Date	Location - City or Town, State
E O	0 0		1 🗷 Burial 2 □ Cremation 3 □ f  1 □ Donation 5 □ Other (Specify)	Removal from State	irematory or other place)  Murch Giroken 7/1	28/07 8	hodge, mel
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens		Pa Name and Address of a Luch	e faminas	secs
	707 e 9		23a. Part 1. Boer the disease, or comp	lications that caused the death. Do not one cause on each line.	5151 Bathmare National Parties of the state		Ho, md 21229 Approximate
8	Pnysician		shock, or heart failure. List only o Immediate Cause (Final disease or condition				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	aDue to (or as a consequence of):	ncepha bonalhy		
W.	LAdillillei	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):	n pheumonia	<i>U</i>	
	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c			19 h
60,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence of):			
68760	ficate physics the t	edical	`	d			
Вох	eath certific attending p	an/M	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery  Month Day Year
	he dea the at thed fo	Physician/M	in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Mona Bay Tour
, P.O	es that the de igned by the a be detached t	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ords	v require been sig should b					1 Tes	2 No 3 Probably 4 Unknown
I Records,	The lav ate has page 2	Completed				24a. Was an autopsy performed 1 Tyes 2 T	24b. Were autopsy findings available prior to completion of cause of death? 1 \( \text{Yes} \) 2 \( \text{No} \) No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		eath (Check only one)	0.500
of	ng Physiter this	-	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)  28b. Time Injur	e of 28c. Injury at	Home 5 Residence	
sior	tending I eath. tor: After the funer	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2 ☐ No	COL Landing (Charles	A Complete of Comp
Division	el or Attend s after death if Director: , id in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)	vsician: To the best of my knowledge, de iner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the vithii To the Comp.	×	29b. Signature and title of certifier	)	29c. License number	29d.	Date signed (Month, Day, Year)
	27		\$ 0	[aur	V 50 641	0	meg 43 200 +
	) '		Ramesh Sabapath	i 201-107 Rack R	liver Nede Road	Baltimore	Mayland 21221
76	Sta Registi		31. Date filed (Month, Day, Year)  JUL 2 5 20	iner: On the basis of examination and/or and manner stated.	bare		

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one and the manual of the medical Examiner must be notified at one and the manual of the medical Examiner must be notified at the medical Examiner must be notified at the medical Examiner must be notified at the medical Examiner must be notified at the medical Examiner must be not the must be not the medical Examiner must be not the medical Examiner must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the must be not the
Baltimore	bearit. Pages 'Department of F Important: If ite and injury or of any inju

			1 - For State Registrar	State of Maryla		artment of F rtificate of			giene Reg. No.	07	23900
B	Physici	an	1. Decedent's Name (First, Middle, La WILFRED	ast)	rllt	ELDS		2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gin	ve street and number)	7 11 7		or Location of Death	July	4c. County		1890 M
1	Examin	er	THE JOHNS HOPKIN			Bultimor					
	Funeral Director		,		rs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da April 2	th y, Yea <i>r</i> ) 29, 1931		lace (State or Foreign try) sachusetts
	Maryland F show fied at	tor	10a. State 10b. County Maryland Anne A		City, Town or L		napolis			1	0d. Inside City Limits
	th with the 23a or 28a ist be noti	al Direc	10e. Street and Number 156 Green Stree	t		10f. Zip Code	21401		10g. Citizen of V	Vhat Coun	•
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show myn Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	rea	1 ☐ Yes 2 🖾 No	•	ecify Yes or No Rican, etc.)	14. Race Blace Specify	e - Americ k, White,	
15-0	"natu "natu edical	letec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occup kind of work done DO NOT use retire	oation during most of work d)	king	16b. Kind of Bu	isiness/Ind	dustry
212	withir jiene.	ошр	Elementary/Secondary (0-12)	College (1-4or 5+) <b>5+</b>	1110.	Presiden			Wateı	Tes	ting
Maryland 2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Las Wilfred Shields	1)			18. Mother's Nam	e (First, Middle, latson	, Maiden Surnam	ne)	
	1 and 2 should Health and Men tem 27 is marke		19a. Informant's Name/Relationship  Jacqueline H. Re	ogers/executo	Green Str	and Number or Rui eet Anna		-		Code) 401	
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or oth		20a. Method of Disposition 1 ☆ Surial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Special Control of the Control			osition (Name of ematory or other pla t Mem. Ga	rdens 7/1	<sup>Date</sup> 4/2007	20c. Location - Annapol	•	
Balti	permit. Departr Importa any injt		21. Signature of Funeral Service Lice	E LIS	<i>- 10 1</i>		ess of Facility JC f Glouces		_		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Multiple Due to (or as a con				or respiratory a	rrest,		Approximate Interval Between Onset and Death
	b.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a con  c. Ansto A  Due to (or as a con		erkdown					3 Months
68760,	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a con	sequence of):	olan Can	ncer				5month
P.O. Box 6	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ f 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc	у			te of delive	ery Day Year
	uires that signed by Id be deta		Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause giv	ven in Part I.		obacco use cont Yes 2 \( \subseteq \text{No}		ne cause of death?
or Vital Records,	> 0 5	Completed by					-		psy ormed?	Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of
r Vital	yslcian: ` is certifica director, p	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outpatie	ent 3 DOA Oth	26. Place of Dear				
Division o	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2		27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not 1			M 1	Yes 2□No		how injury occur		
Divis	ital or Att rs after de ral Direct led in by I	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		At home, farm, s pecify)	treet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	il Route Number,
	the Hosp vin 24 hou the Fune upletely fill	Medical	(Check only 2 ☐ Medical Exa	Physician: To the best of my aminer: On the basis of exar and manner stated.		nvestigation, in my	opinion, death occu		date and place,	and due to	o the cause(s)
2)	1 × / °	S	29b. Signature and title of certifier	35/	~0	29c. Licens	se number		29d. Date signe		Day, Year)
_	IN COR		30. Name and address of person who	The Tohastlook	Con Harat	-11 600 V W	-olfest. Bu	itimore,	mo 212	7	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 10	22 Projetrario C	ignature	Sporte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ID: IDAM James 07 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Hospice Baltimore 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day 03 15 5. Social Security Number 25 · 70 · 5813 Age (In vrs. last birthday) **Funeral** Days Months MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count show r 28a-f show notified at 1 XYes 2 □ No MD Baltmore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner πust be i 1425 North Central Avenue 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Specify Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) Baltimore 200 9th grade Maintenance Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith 8mith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informan's Name/Relationship (Type. Print) Baltinore, MD 21239 Department of Health ar Important: If item 27 Is any Injury or other trau Ayleshire Raymond Smith Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation Windsor Mill, MD King Memorial Park 26/51 4 Donation 5 Dother (Specify) Varighy C. Green e Funeral Sucs 21. Signature of Funeral Service Licenses 4905 York Road Hmore, MD 2/2/2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** una cancer uear /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) physician s the burial Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Yoo 24a. Was an autopsy perform 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After t 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Eutaw St Baltimores

31. Date filed (Month, Day, Year)

Medical

29a. Certifier

State Registrar Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

07-05495

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ellis George Spenc			St	ate of N	Marylar	nd / De	epartr Certifi	ment of icate of	Healt Death	n and	Menta	al Hygie	ene Reg.	No.	6 ··	7
Physician/	_	gistrar Decedent's Name	(First, Middl	e,Last)									ate of Death		Year	3. Time of Death
Medical Examiner	H	Ellis G	eorge	Spe	ncer	Jr.							onth Iy 17, 200			1151 hrs
<b>4</b>	4a	. Facility Name (if	not institution	n, give stre	et and num	ber)			4b. City, To		ocation of	Death		Harfo	nty of Death ord	10
	_	Upper Ches				'. Age (In	ure (set )	hirthday)		r 1 Year	If Under	24Hrs. 8.	Date of Birth(			thplace (State or
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5-0036 led within 72 hours after death yegiene. other than "natural", or iter the Medical Examiner must. Commoleted by Fund	3 1	7. Father's Name	(First, Middle	e, Last)									st, Middle, Ma Naomi			
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been similar in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	ပ္ပုံ	25. Was case refe	erred to med	ical						26.Plac		n (Check on				
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the IIs hin 24 the Fo	Medical	(Check only one) 2	/ Medical E	xaminer:0	n the basis	of exami	ination ar	nd/or invest	igation, in	my opinio	on, death	occurred at	the time, date	and place	e, and due t	o the cause(s)
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5+1	-	30. Name and ac	dress of per								lain	MD 040	01			
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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		rtificate of Death	, 0	eg. No.	· · · · · · · · · · · · · · · · · · ·						
	Physici	on	1. Decedent's Name (First, Middle, Last)			2. Date of Death	h Day Year	3. Time of Death						
Щ	Physici /Medic		Amelia Sadie Shaw			July	21,2007							
	Examin	er	4a. Facility Name (If not institution, give street and number)	*	4b. City, Town, or Location of Death	1	4c. County of Deat	h						
	er house was a state of		Harford Garden Convales	cent rs. last birthday)	Baltimore If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	N/A	hplace (State or Foreign						
	Funeral Director		241-40-3747 1□ M 💯 F 79  Usual Residence of Decedent	Yrs.	Months Days Hours Min.	(Month, Day, 1-6-1	Year) Co	arolina						
	ryland how at			City, Town or Lo	ocation			10d. Inside City Limits						
	e Ma 3a-f s tified	cto	Md. N/A	Baltim	nore			1 TYes 2 No						
	or 28	Dire	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	untry?						
	ath w	ral	2713 Fisk Road		21225		USA							
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ ▼Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (S If Yes, specity Cuban, Mexican, Puert 1 ☐ Yes 2∏ No Specify:	pecity Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: B1	e, etc.						
21215-0036	72 hou natura iical E	ted !	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	kina	16b. Kind of Business/							
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ary	should and Men s marke rumatic	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Number or Ru			Zip Code)						
	1 and 2 Health a em 27 Is		Larry Shaw Sr. Son		Chesterfield	Ave,Bal	timore, M	d.21213						
Baltimore,	Pages 1 nent of Ha int: If iter		20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State	<ul> <li>Place of Dispo cemetery, crei</li> </ul>	sition (Name of matory or other place)	Date 2	20c. Location - City or	Town, State						
<u>Ħ</u> .	permit. Pages Department of Important: If it any injury or c		4 □ Donation 5 □ Other (Specify)	letro C	rematory 7-27	-07 C	atonsvil	le,Md.						
Ba	permit. Departr Importa any injt		21. Signature of Funeral Service Licensee	Ê	Name and Address of Facility Step Brothers 300 Eutaw Plac	Funeral e,Balti	Ser,P.A more,Md.	$\dot{2}1217$						
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Division or	or Attending Ph ufter death. Director: After thi in by the funeral	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office	28f. Location (Str	eet and Number or Ru	ıral Route Number,						
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my leading the composition of the best of examiner: On the basis of examiner and manner stated.	knowledge, deatl ination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the ca irred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)						
	Vithi To the	×	29b. Signature and title of certifier		29c. License number		d. Date signed (Monti							
		ļ	Ng M2		64443		UT-24-	-07						
	12		30. Name and address of person who completed cause of death (I	tem 23a) (Type,	1 UGOOF Ralt.	201010	07-24- MD2	1201						
150	Sta	te	31 Date filed (Month, Day, Year) 32 Registrar's Signature (Month)	gnature	- Vica , Juli	····	100-00	1201						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 7 1 1 0 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Anna Margaurite Smith 11:00 A.M Ju1v19 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3814 Fairhaven Avenue N/A Baltimore 1 Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🗓 F 232 44 8157 85 1921 Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Natical Exeminar must be notified at 1 ¥ Yes 2 □ No Marvland N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 3814 Fairhaven Avenue 21226 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Markel Examination once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Waitress Bush Chesapeake 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morton Ray Blackwell Opal Reilly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Smith / Son 3814 Fairhaven Avenue Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Bayview Crematory 7/20/2007 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signal of Eureral Service Liger 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Small Cell Lung Concer uence of): TTETIC TO LIVER Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes 2 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 ☐ Yes 2 ◯ No ome Residence 6 Other (Specify)
28d. esc be how injury occurred P this s after death.
If Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification; Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in a stated. 24 hours completely filled 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar ano

32. Registrar's Signature

California .

Hospital Drive Glea Burne MO266

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

6019

660

Mayer

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 13:35 M III Souders harles Howard Jule 19 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Batamore UMMC 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2□ F 213-32-9123 Director July 24, 1933 Maryland 73 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Harford Aberdeen 1 ☐ Yes 2 ☐ No Maryland Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 700 W. Bel Air Avenue Apt 120 21001 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natur any lijury or other traumatic event, the Medical once, once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Dispatcher Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles H. Souders, Jr. Marion Martha Carroll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cousin Lawrence V. Conelius 101 W. Mapledale Avenue; Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. 7/24/2007 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature ... LService Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to was a smooth state of the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Approximate Interval Between Onset and Death days **Physician** /Medical Due to as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 | **X**0 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After t Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar

Jia 31. Date filed (Month, Day, Year) JUL 2 5

29b. Signature and title of certifier

one)

S. Greene 327Registrar's Signature

22

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

114442204

St. Batumove

29d. Date signed (Month, Day, Year)

200

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1/ per fh 8869 7-25-07 vt
State of Maryland / Department of Health and Mental Hygiene
Amend Item 5 per int., 8878, 04718 (28th)

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY 5:30A **SCHULDENFREI** 23 2007 REGINA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5833 PARK HEIGHTS AVENUE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/25/1911 9. Birthplace (State or Foreign Country)
POLAND 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Months Days Hours 95 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21215 USA 5833 PARK HEIGHTS AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH BERGMAN SCHULDENFREI FAGIE UNOBTAINABLE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 6503 WESTERN RUN DRIVE, BALTIMORE, MD ALLEN SCHULDENFREI / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State AGUDATH ISRAEL 07/23/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause La each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Jean disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burst-transit completely filled in by the funeral director, page 2 should be detached for use as the burst-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 4 W Belveder 31. Date filed (Month, Day, Year) JUL 2 5 State Registrar

1 - For State Registrar
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Reg. No.	- "	, a	

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<b>Physician</b>	
/Medical	
Examiner	

Funer Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medic Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

		Registrar				Cer	uncai	le oi i	Dealli			Reg. No.		
icia dic	in	1. Decedent's Name SIDNEY	(First, Middle	, Last)				SAK	OLS		2. Date of De Month JULY	ath 22	2007	3. Time of Death 4:40P M
nine		4a. Facility Name (If			•		-		r Location	of Death		4c.	County of Deat	
-X-		MARYLAN  5. Social Security No		RAL HOSPI	TAL 7. Age (In yrs.	leet hirthday)		BALTI er 1 Year		r 24 Hrs.	8. Date of Bir	th	N//	hplace (State or Foreign
al or		218-14-6 Usual Residence of	651	6. Sex 1	90	Yrs.	Months		Hours	Min.	11/23/	1916	Co	MD
		10a. State	10b. County		10c. City	, Town or Lo	cation	-						10d. Inside City Limits
	ţ	MD		N/A	В	ALTIMO	RE							1 <b>X</b> Yes 2 ☐ No
	irec	10e. Street and Nun	mber				10f. Zi	p Code				10g. Citi	izen of What Co	untry?
	al D	815 DRUI	D PARK	LAKE DRI	VE			21	.217				USA	
	Funeral Director	11. Marital Status		Armed Fo	edent Ever in U.	S. 13. \	Nas Dece f Yes, spe	edent of Hecify Cuba	lispanic O an, Mexica	ngin? (Spec an, Puerto F	cify Yes or No Rican, etc.)	-	<ol> <li>Race - Ame Black, White</li> </ol>	
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	To Be	17. Father's Name (		Last)		SAK0	LS			ANNAH	(First, Middle,	, Maiden	Surname)	LEVIN
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		20a. Method of Disp		3 □Removal from	State 20b. F	lace of Dispo emetery, crer NSHE El	sition (Na	me of other plac	ce)	Da	ate	20c. Lo	ocation - City or	Town, State
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once.	i	21. Signature of Fu	ineral Service	Licensee	-				ss of Faci				& BROS	., INC. , MD 21208
5		23a Part1 Enter th	he disease or	complications that	caused the deat								ESAILLE	Approximate Interval Between
n		shock, or hea Immediate Cause ( disease or condition	ırt failure. List Final	only one cause on e	RATION				3,		,	,		Interval Between Onset and Death
ai er		resulting in death)		STAP	(or as a conseq H AURAS	uence of): BACTE	REMI	A						
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	Ě	resulting in death) t	Last	Due to	(or as a conseq	uence ot):								
	dice			d										
	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	1 ☐ Live	tcome pf pregna birth 2 □ Feta nant at time of d own	Ideath 3	Ectopic p		у				23d. Date of del Month	ivery Day Year
}		Part II. Other signif	ficant condition	ons contributing to d	eath but not res	ulting in the u	nderlying	cause giv	en in Part	t 1.	23e. Did 1	tobacco	use contribute to	the cause of death?
	d b										1 🗆	Yes 2	□No 3□Pi	robably 4 Unknown
	Completed by										24a. Was auto perfo		24b. Were au prior to death?	utopsy findings available completion of cause of
		25. Was case refer	red to medica	1					26 Plan	ce of Death	(Check only		1 □ Yes	2 No
	To Be	examiner? 1 □ Yes 2	No	Hospital: 1	Inpatient 2 ☐	ER/Outpatier	nt 3 🗆 D	OA Oth	er.				6 □Other (Spe	cify)
	tion: 1	27. Manner of Death 1 Natural 2 Accident	h 5 □ Pendin investi	9	of Injury oth, Day Year)	28b. Time o Injury	f M	28c. Injui Wor 1 □	ryat rk? Yes 2 [		8d. Describe	how inju	ry occurred	
	ertifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could i determ	ined   Zoe. Flat	e of injury - At he ling, etc. <i>(Specil</i>	ome, farm, str	eet, facto	ory, office		2	8f. Location ( City or To	Street ar wn, State	nd Number or Re	ural Route Number,
	Medical Certification:	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To the Examiner: On the I	e best of my kno casis of examina nner stated.	wledge, deat ation and/or in	h occurre vestigation	d at the ti	me, date a opinion, de	and place, a eath occurre	and due to the ed at the time	cause(s , date an	and manner as d place, and due	s stated. e to the cause(s)
	Me	29b. Signature and			42		25	9c. Licens	se number	r		29d. Da	te signed (Mont	h, Day, Year)
		1	Saac	A. Hay	Mas M			RES-	-000			C	7/22/20	07
		30. Name and addr	ress of person	who completed cau RYLAND GE	se of death (Iter	n 23a) (Type, IOSPITA	Print)	17 L	INDEN	N AVE.	, BALT	IMOF	RE, MD	21202
Sta		31. Date filed (Mon	nth, Day, Year)	32.1	Registrar's Signa	ature	bore							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Cecelia Marie Szymkowiak 23, 1:00 P<sup>M</sup> July 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Augsburg Lutheran Home 5. Social Security Number | 6. Sex | 7. A Baltimore Reisterstown 8. Date of Birth 9. Birthplace (State or Foreign Mary Land Age (In vrs. last birthday) **Funeral** Days Nov23, 1918 1 □ M 2√ F 213-18-6853 88 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it I flem 27 is marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 is marked other than "natural", or hems 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Md n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Completed by Funeral 354 Gusryan Street 21224 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George\_A. Szymkowiak ပ Stella Bertha Sporny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose C. Davidson (daughter)7305 Castle Moor Road Baltimore, Md. 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-28-2007 Baltimore, Maryland Holy Cross PNCC 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee Job 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Althorselerotic Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. 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Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autoosy performed' 1□ Yes 2⊋No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar (Check only one)

29h. Signature and utle of sertifier

31. Date filed (Month, Day,

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Year)

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sea 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smi

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32. Regis ar's Signature

29c. License number

Ave Suite 203

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 11:40a. 22 2007 Richard Ell 4a. Facility Name (If not institution, give street and number) July Ellsworth Turner Sr. 4b. City, Town, or Location of Death 4c. County of Death 1818 Appleton Street Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) . Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Months 1XM 2□F Yrs 216-16-5652 Usual Residence of Decedent 84 24 MD 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Y Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 1818 Appleton Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: Black 3 ☐ Widowed 4√ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service Mail Handler 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Talbert A. Turner <u>Cora Wallace</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 James Turner-Son 3643 Clifmar Road, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 7/31/2007 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, Md 21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disear e or condition ANCER TROSTATE ting in death) Due to (or as a consequence of): 1.1 23d. Date of delivery Month use contribute to the cause of death? No 3 Probably 4 Unknown

Physician /Medical Examiner

use as the burial-tran

signed by the a id be detached for

in by t

completely

Medical

(Check only one)

29h. Signature and title of certifier

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be P

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar process.

Physician/Medical Examiner Completed by Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Hypremoves Trovenia  Due to (or as a consequence of):  d. Arthuris	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☑ 1 ☐ Probably 4 ☐ Unkr
		24a. Was an autopsy performed? 1
25. Was case referred to medical examiner?		h (Check only one)
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA Other: 4   Nursing Ho	ome 5 Aesidence 6 Other (Specify)
27. Manner of Death 1 □Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 CertifyIng Ph	ysician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated.

State

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 Nort North Eutaw St. Suite 103, Baltimore, Md 21201 Anwar Khokhar, 31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D32700

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

2007

29d. Date signed (Month, Day, Year)

JUL 25 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROST **Physician** 6.05 KM SANDREA 2007 /Medical 4b. City, Town, or Location of Death **Columbia** 4c. County of Death Howard 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Date of Birth (Month, Day, Year) March 3, 1921 Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 214-10-5427 Months Hours Min. Maryland 1 □ M Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intt of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a, State 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If Item 27a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M. dical Examiner must be notified at Maryland Howard Elicott City 1 ☐ Yes 2 No Director 10g. Citizen of What Country U.S.A. 10e. Street and Number 10f. Zip Code 21043 4714 Hale Haven Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 210 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 25 No Specify: þ Specify. White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Stockman Franklin Scott Weltz P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4714 Hale Haven Dr. Ellicott City, Maryland 21043 Ms. Antoinette Shively Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Decremation 3 ☐ Removal from State 07/27/07 Sykesville, Maryland All County Cremation Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enterine diseas shock, or heart failure. omplications that caused he only one cause on each lim. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Bacterial Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tenotic Careliovan adar Diseare Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 290. Signature and title or certifier

| D SO 641 | July 24 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
| Rame 1h Sabar paths 201-109 159016 RIVEN NICK Road Baltimer Maylind
| 291. License number | 292. License number | 294. Date signed (Month, Day, Year)

| July 24 2007 | 7
| Rame 1h Sabar paths 201-109 159016 RIVEN NICK Road Baltimer Maylind

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signeture

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2. Date of Death

3. Time of Death

For State Registrar Amend 28a-f, perME, g871, 9/28/07 TT Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items State of Maryland / Department of Health and Mental Hygiene

20a,b,29d per FH/Dr. 8869,07/35/07dhb

Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 338M 2007 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 213015 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours 1 ■ M 2 🔀 F 213-34-236 TEORGIA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1XYes 2 No Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or I any ijury or other traumatic event; the Medical Exemit once. 1 ☐ Yes 2 No <u>م</u> 3 Widowed 4 Divorced Be Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) URNER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHA 20a. Method of Disposition Date 20c. Location - City or Town, State Metro 1) Surial 2 Tremation 3 ☐Removal from State BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** kssive intrabdomina /Medical Due to (or as a consequence of): **Examiner** sign nitroly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitai or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

 $\mathcal{L}(\mathcal{M})$ Division or Vital Records, P.O. Box 68760,

within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

29b. Signature and title of certifier

29a. Certifier

OUNOMO 31. Date filed (Month, Day, Year) JUL 2 5 2007

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month) 0**7/12/20**07

30. Name and address of person who c pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

### 07-Wil

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edical Examiner		Wilb	ert	Lee		Terr	У				21, 2007	c. County		
(		Facility Name (if not institutio		umber)		4t	City, Tow		cation of D	eath		,	o Doda	
		Johns Hopkins Hospit	al .				Baltimo		(61)	Alles 10 Dr	ate of Birth(MN	NA WDDYYYY	9. Birthpl	ace (State or
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5-0036 led within 72 hours after bygiene. other than "natural", the Medical Examiner Completed by	17	9th grade . Father's Name (First, Middle	e, Last)			<u> </u>	10100	1	8.Mother's	Name (First	, Middle, Maid	en Surnam	ie)	
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212 212 Mild be Ment mark c ever	19	a. Informant's Name/Relation	ship (Type, Print )		19	b. Mailing	Address	(Street	and Numb	er or Rural I	Route Number	, City or 10		
MD d 2 sho fith and m 27 is		Sandra Cohen	Mother	in Law		2709	Oakl	ey_	Ave	Balt Dat	imore,	Md c. Location	21215 n - City or T	own, State
e, land Health	20	a. Method of Disposition	a Dameur		0b. Place? crema	of Dispos atory or ot	ition (Name ner place)	e or cerr	netery,	Dat				
10 T ages I nt of I	1	X Burial 2 Cremation Donation 5 Other	on 3 Remova	I II OIII State	King		ı. Par			7-27-	07	Randa	allsto	own, Md.
Baltimore, permit. Pages I an Department of Hee Important: If ite	21	. Signature of Funeral Service	e Licensee				Name and A			Mar	ch F.H.	East	t _	
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Maria To. Be Con		(SOAV M. SA	/			]	.101 E	. N	orth	Avenu	e, Balt	imore	e, Md.	21202 Approximate Interval
Physician	23	Ba. Part I. Enter the disease, failure. List only one caus								rdiac or resp	oratory arrest,	SHOOK, OF	Tourt	Between Onset and Death
* Tedical	l In	nmediate Cause (Final diseas	T7. 1	1, cocai	ne and	l hero	in int	oxica	ation					2000
1 aminer	0	r condition resulting in death)	Due to (or a	s a consequer	nce of):									
		equentially list conditions,	b. Due to (or a	as a conseque	nce of):									
	⊑lc	any, leading to immediate ause. Enter Underlying Caus	se c.										_	
11. =	(lar	Disease or injury that initiated vents resulting in death) Las	Due to (or a	s a conseque	nce of):								- 1	
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exe	8	X UNPENDED		11 <b>pe</b> 27,28a-f			0, 8/9	/07	TT				e of delivery	
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be exert as after death.  The law been signed by the attending physician a birector: After this certificate has been signed by the attending physician a led in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medica	FEMALE: Bb. Was decedent pregnant in		es, outcome of ve birth	f pregnand	-	etal death	3	Ectopic	pregnancy		Monti		ay Year
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Divi	ÐΙ	- Golde	Could not be		ınd at					51	1 E. 22n	ďSt.	Baltim	ore, MD
Ospit: hour uners		4 Homicide 29a. Certifier 1 Certifyin	g Physician: To th				curred at th	e time,	date and pl	ace, and du	e to the cause	(s) and ma	anner as sta	ted.
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.		(Check only one) 2 Medical	Examiner:On the b	asis of examin	ation and	or investi	gation, in m	y opinio	on, death o	ccurred at the	ne time, date a			
To To Yourth COURT	릙	29b. Signature and title of ce	allu Illali	ner stated.					nse number			29d. Date	signed (M	onth, Day, Year)
		Qto: As	100 11	- Pa	P Dal	c vu	ا ۵	0.0	C.M.E.			July 22	, 2007	
	-	30. Name and address of pe	rson who completed	cause of dea	th (Item 23									
0		Patricia Aronica-Po		sistant Me	dical Ex	aminer	111 F	enn :	Street, B	altimore,	MD 21201			
	ate	31. Date filed (Month, Day, Y	ear) 2207	2. Registrar's	Signature	do	uf)							
Regist	trar	JUL 2	3 ZUUT	ماناس الراسا	July !	1	-							

DHMH 17 Rev 1/2001 OCME 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mi	aryland /	•	tificate of		Weritai m	Reg. N		Te Islandia
	J. 5.		Decedent's Name (First, Middle, La	ast)					2. Date of D	eath	t	3. Time of Death
	Physici /Medic		Claude	Tor	rence				July	18	ay Year 7	10:41PM
*	Examin		4a. Facility Name (If not institution, gire				4b. City, Town, or		ath 0	4	c. County of Death	
AC.			5. Social Security Number 6.		PITAL	inth day)	ISALT If Under 1 Year	IMON?	re   0 Date of D	inth	N/A	- 1000 / Chaha
	Funeral Director				e (In yrs. last bi	Yrs.	Months Days	Hours Mi		-52	Bal	place (State or Foreign ntry.) timore, Md.
	/land ow at		10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside City Limits
	a-f sh ified	ţċ	Md. N/A		Balt	imo	$_{ m re}$					1 Tres 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	ntry?
	ath w	ral	3804 Fairview				21216				USA	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes Yill If Yes, Give Year or Dates:		- 1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 1 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	lo-	14. Race - Ameri Black, White, Specify: B1:	etc.
2-0	72 ho 'natur dical	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a	. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of w	orking	16b.	Kind of Business/Ir	dustry
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Maryland	2 should be f and Mental I is marked of raumatic eve	-	19a. Informant's Name/Relationship		19	b. Mailin	g Address (Street			_	or Town, State, Zij	o Code)
	1 and 2 Health em 27 i		Thelma Wright	Sister	3	804	Fairvi	lew Ave				and 21216
Baltimore,	e = 1°		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci	fy)		ern	sition (Name of natory or other place Cemete:	ry 7/	Date 26/07		Location - City or T ltimore	
Bai	permit. Par Departmen Important: any Injury once.		21. Signature of Funeral Antice Lice	nse D		Es 13	Name and Addre	ss of Facility Others LW PLac	Funera e Balt	1 Se	er,P.A. re,Md.2	1217
ı,			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do	not ente	er the mode of dyin	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a.	Ser	515					3	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence							
8		P P	Sequentially list conditions,	b. Due to (or as	a consequence		NONIA.					
a .	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linear Unionity ling Cause (Disease or injury that initiated events		,	,-						
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P.O. Box	The law requires that the death cert te has been signed by the attendin age 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)	/			23d. Date of deliv Month	ery Day Year
	res that igned to be det	by P	Part II. Other significant conditions	A 1		in the un	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?
ord	w require been sig should t	ted t	CVA.	Aphalla	<b>1</b> · ·				. 1	Yes :	2 🗓 № 3 🗌 Pro	bably 4 □Unknown
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or Vital	2 8 8 1	Be	25. Was case referred to medical examiner?	Hospital:			Oth		eath (Check only			- miles - street
o	Physer this eral di	): To	1  Yes 2 No 27. Manner of Death	28a. Date of Inju	nt 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Time of	28c. Injur	v at	Home 5 ☐ Res 28d. Describe		6 ☐Other (Speci	fy)
ion	Attending F r death. ector: After by the funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day	y Year)	Injury	M 1 □	k? Yes 2 ∐ No				
Division	al or Attend after death. I Director: A d in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju- building, etc	ury - At home, fa c. (Specify)	arm, stre	eet, factory, office		28f. Location City or To	(Street a	and Number or Run te)	al Route Number,
	To the Hospital or Atter within 24 hours after der To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	f examination a	je, death nd/or inv	occurred at the tir	me, date and pła opinion, death oc	ce, and due to the	e cause( e, date a	s) and manner as s nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	ATTER	10144		29c. Licens		20		ate signed (Month,	
					PHYSIC		1	0 699	59.	VU	14 19	0000
	6		30. Name and address of person who	GOOD.	samar		W Ho	N-00	را ر	3AL	114 19 7111080	MD
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 2 5 20		ar's Signature	Con	de		,			

			State Registrar		•	Cert	tificate of	Death		Reg	g. No.	11	2022
			1. Decedent's Name (First, Middle, I	.ast)						e of Death			3. Time of Death
	Physici Medic		Francis Ar	thony Tro	tta				Ju.	1v 24		ear	6:20 A™
	Examir		4a. Facility Name (If not institution, g				4b. City, Town,	or Location of Death			4c. County of E	Death	
aft.			Stella Maris				Timon	ium			Balti	more	!
	Funeral	2	Social Security Number     6.	Sex 7. Ag	e (In yrs. k	ast birthday)	If Under 1 Yea Months Days			e of Birth onth, Day, Y	Year) 9.	Birthplac	ce (State or Foreign
- 1	Director		067-16-8215	TIZA INI ZLI P	36	Yrs.			Dec	24			York
	nud W		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	ation					104	. Inside City Limits
	shors shore	'n	MD Baltin	ORG		.monium						100	1 ☐ Yes 2 ☑ No
	the N 28a-f lotifii	Director	10e. Street and Number		1 1	יווט דו וטווו.	10f. Zip Code			100	g. Citizen of Wha	t Country	
	with a or	Ē			1.4					100		Country	, :
	death with the Maryland rms 23a or 28a-f show r must be notified at	era	2525 Pot Sprir  11. Marital Status	12. Was Decedent		S. 13. W	21 093	Hispanic Origin? (Si	necify Ye	s or No-	USA 14. Race - A	American	Indian.
6:20 A.M. Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show with Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		II #	Yes, specify Cu	Hispanic Origin? (Span) Hispanic Origin? (Span) Hispanican, Puerto Specify:	o Rićan,	etc.)	Black, V Specify:	Vhite, etc	ite
5-0	72 h 'natu dical	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Decede	ent's Usual Occi	upation e during most of wor red)	king	16	6b. Kind of Busine	ess/Indus	stry
2	/ithin ne. han '	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)			red)	_				
2	led w lygie her tl	ပိ	17. Father's Name (First, Middle, La	2		Ma	chinist	18. Mother's Nam	an /First		anufactu	ring	
anc	he fi	Be		ntta				Suzani		Santar	,		
₹	d Mel nark	은	19a. Informant's Name/Relationship			10h Mailine	Addrona /Stra	et and Number or Ru				4- 7:- 0	
A./	d 2 sl th an 7 is r traur		Patrick Trotta (					Road, Ba				21 <b>0</b> 1	_ ^
o <b>o</b>	1 an Heal Gern 2		20a. Method of Disposition		20b. Pl	lace of Dispos	ition (Name of	1	Date		Oc. Location - City		
: 20 nore	ages int of t: If it		1 █ Burial 2 ☐ Cremation 3				atory or other p	i i	70 /Or		· ·		
Hin	lit. Partme		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lig		TTaue	A NaTT	Name and Add	Grds 07/2	2//U	/	Timonium	, Ma	ryland
Ba	permi Depar Impor any Ir			_				ress of Facility Ruo			21204	HOM	e, Inc.
	Costs		23a. Parti. Enter the disease, or co	mplications that caused	the death		and the second s	Road, Tol ving, such as cardiac				A	pproximate iterval Between
	STATE OF THE STATE OF		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lir	ie.	)	11	1	1	,	•	lr C	iterval Between Inset and Death
	Physician /Medical		disease or condition resulting in death)	a. On Due to (or as	_	STIVE	Hea	rt 10	CITO.	12		-	Weeks
	Examiner			CL		2	engl	Failu	10			ļ	4 ears
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as			Chiqu	1 01101					1 2
	uted d ansit	i i	cause. Enter Underlying Cause (Disease or injury										
3,	exec in an	Examiner	resulting in death) Last	Due to (or as	a consequ	ence of):							
4, 2007 <b>68760</b> ,	ertificate be executed ing physician and e as the burial-transit	Medical		d									
4,89	tifica ig ph as th	ledi											
JULY 2.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify)			_	23d. Date of Month		ay Year
σ,	that ned by deta		Part II. Other significant conditions	contributing to death b	ut not resu	alting in the un	derlying cause g	given in Part I.	23	le. Did toba	acco use contribu	te to the	cause of death?
TROTTA or Vital Records	uires n sign ld be	d by								1 ☐ Yes	2∑ No 3[	] Probab	oly 4 □Unknown
00	w rec	Completed							24	a. Was an	24b. Wer	e autons	v findings available
Re	he la e has ige 2	Ę.								autopsy performe	ed?   deat	th?	y findings available pletion of cause of
T'T'A	ificate		25. Was case referred to medical	1				26. Place of Dea			No 1 🗆	Yes 2	<b>☑</b> No
TROTTA or Vital	s cert irect	o Be	examiner? 1 ☐ Yes 2⊠`No	Hospital: 1 ☐ Inpatie	nt 2□	ER/Outpatient	30,004	thor:			ce 6 □Other (	0:6.)	
	Phy er this eral d	٠: <u>۲</u>	27. Manner of Death	28a. Date of Inju	ry	28b. Time of	28c. Inj		11		v injury occurred	Ѕресіту)	
NK	th. :: Afte	tio	1. Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	y Year)	Injury		ork? □Yes 2□No					
FRANK Division	Atter r dea ector by the	tica	3 ☐ Suicide 6 ☐ Could not determine		ury - At ho	me, farm, stre	et, factory, offic	e	28f. Loc	cation (Stre	eet and Number o	or Rural F	Route Number,
Di	al or afte	Certification:	4   Hornicide	building, et	э. (эреспу	′)			OII.	y or Town,	State)		
	he Hospit n 24 hours he Funera pletely fille	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis o and manner sta	examinat	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and place y opinion, death occu	e, and due	e to the cau	use(s) and manne te and place, and	er as stat due to t	ed. he cause(s)
	To the To the To the Comp	ž	29b. Signature and title of certifier	1. (		11	~	nse number	~	290	d. Date signed (A	fonth, Da	ay, Year)
	1		1 Amest	ine VC	yng	ut, M	) D	25741		_	PluL	24	WS007
1	51		30. Name and address of person wh	o completed cause of d	eath (Item	23a) (Type, F	rint)			1			
1	0		ERNESTINE WRI				Y VALLE	Y ROAD T	IMON	IUM,	MD 21093	3	
	Sta		31. Date filed (Month, Day, Year)	5 2007 32. Registr	ar's Signat	ture	hack .						
	Regist	aľ	00L K	- Lucia	Service of the service of	N. JG							

DHMH 17 Rev 1/2001

### 07-05221

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

William Leroy Ur		Joh State	State of Mar	yland / [	Department of Certificate of			Mental H	ygiene			
Physicia	_	Registrar  1. Decedent's Name (First, Mid	idle,Last)			Dout	<u> </u>		2. Date of D	Reg. No.	1	3. Time of Death
Medical Exami			eroy Urs	pruch					Month July 7, 2	200 <b>7</b>	Year	2215 hrs
product in		4a. Facility Name (if not institu		·		4b. City, T	own, or Lo	cation of Deati			County of Dea	ath
		Wye Island Road				Quee	nstown			Q	ueen Anne	e's
Funeral		5. Social Security Number	6. Sex	7. Age (I	n yrs. last birthday)		If Under 1 Year If Under 24Hrs  Months Days Hours Min			Birth (MM/I	DD/YYYY) 9. E Fore	Birthplace (State or
Director		214-62-0883	1 X M 2	F	55 Y		S Days	Hours Mir	Janua	4 25,19	952 (	Country) Maryland
>		Usual Residence of Decedent		Ido	Oit. Town and an	tion.						10d. Inside City Limits
w any		10a. State 10b. Count		10	c. City, Town or Loca							1 Yes 2 No
/land	ţō	Maryland To  10e. Street and Number	ubot		51	10f. Zip				140m Citie	zen of What Co	
Mar r 28a	Director					101. ZIP		2		Tog. Citiz	US.	
ith the 23a o notifi		11. Marital Status		Decedent Ev	ros in II S I 13 M	lac Decede	2160	enic Origin? ( S	nacify Vac or	No.		erican Indian, Black,
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Married 2 X	Married Arm	ed Forces?	If			Mexican, Puert		110-	White, etc.	
ter de		3 Widowed 4 [	1 Y Divorced If Yes, Giv	es 2 X e Yeer		Yes 2	X No	specify:			Specify: V	Vhite
ours ad atural	d by	15. Decedent's Education (S	pecify only highest	grade comple				n (Give kind of		16b. K	(ind of Busines	s/Industry
72 ho	lete	Elementary/Secondary (0-1	2) Colle	ge (1-4 or 5+)	dunng		_	OO NOT use re	tirea)			
03( vithin ene.	Completed			3		Pair	nter					red Painter
Filed v Hygi d oth		17. Father's Name (First, Midd					18	Mother's Nam	e (First, Midd haclett		Surname)	
12 11 14 be Id be narke event	To Be	19a. Informant's Name/Relation	nation Urse Print		19h Maili	na Address	(Street	_		,	ty or Town, Sta	ate Zin Code)
ID 2 shou and N 27 is matic	F	Faith Wilson		,								21620
and 2 and 2 tealth item 2 trau	- 3	20a. Method of Disposition		<del></del>	20b. Place of Disp	osition (Nar	ne of ceme		Date			or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremat		val from State	Anatomy Git			3	. 13 700	7 6	anover	MA
it. P. artmer ortan	1	4 ➤ Donation 5 Other  21. Signature of Funeral Servi			22.	Name and	Address	of Facility And	trong G.F	to Reco	Star	
Den Den Inji	. 8	50	>		75	22 Cor	nelley	Drive 50	ite P. H.	thover	, MD 21	076
Physician		23a. Part I. Enter the disease,		hat caused the	e death. Do not enter	the mode	of dying, s	uch as cardiac	or respiratory	arrest, sho	ock, or heart	Approximate Interval Between Onset and
Medical Examiner	- 2	failure. List only one cau Immediate Cause (Final disea	I-4	al gunshot	wound							Death
Examine		or condition resulting in death		as a consequ	uence of):							
	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ience of):							
	Examiner	couse Enter Underlying Cou (Disease or injury that initiate	Sia C	as a consequ	201100 0171							
d d	xar	events resulting in death) Las		as a consequ	uence of):							
O, e be executed ysician and burial - transit	Sal	LINDENDED	d	)				<del></del>				<del> </del>
O, e be ex sician sician	edical	UNPENDED	AMEN							Lon	d Data of date	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/M	IF FEMALE: 23b. Was decedent pregnant in	a Ale a	yes, outcome .ive birth		etal death	3	Ectopic pregr	nancy	230	d. Date of deliv Month	Day Year
X 6	icia	past 12 months?	7	Pregnant at tin	no of dooth	Other (Spe	cify)					
Box le death of the atten	Phys			Jnknown					00 - D			to the course of death?
that th	by P	Part II. Other significant con	iditions contribut	ing to death b	out not resulting in the	underlying	g cause giv	en in Part I.				to the cause of death?
IS, P.C quires that en signed					<del></del>				24a. W	=/		autopsy findings available
cords, law requir has been s	Completed								а	utopsy erformed?		to completion of cause of
Rec The la	[등									es 2 N		
tal Reccian: The l	Be	25. Was case referred to med examiner?	Hospital:				10	of Death (Check				
of Vit ing Physic After this Cuneral dire	ုင္	1 ✓ Yes 2 No 27. Manner of Death	<u>'</u>	Inpatient Date of Injury			28c. Injury	- Tuis	ing Home 5		ence 6 🗸 Ot	her: Scene
Division of Vital Records, tal or Attending Physician: The law require is after death.  al Director: After this certificate has been si led in by the funeral director, page 2 should b	e .	1 Notural	ending Jul	Month, Day, Year 7, 2007	r) 1903 hrs	i injury		es 2 V No	Subject s			
ivisior or Attenc after death Director:	cati	2 Accident In	vestigation	Place of Injur	ry - At home, farm, st	eet factor			28f. Locatio	on (Street a	and Number or	Rural Route Number, City
Divi	Certification:	d	ould not be	ecify) Woo	•	000, 100101,	,,		or Tow	n. State)	Queenstown,	
Div To the Hospital o within 24 hours af To the Funeral D		4 Homicide 29a. Certifier 1 Certifying			nowledge, death occ	urred at the	e time, dat	e and place, ar	1			
the P thin 2- the F	Medical	(Check only one) 2 ✓ Medical E	xaminer:On the b	asis of examin	nation and/or investig	ation, in m	y opinion,	death occurred	at the time, o	ate and pla	ace, and due to	the cause(s)
To will	Me	29b. Signature and title of cer		ner stated.		29	c. License	number		29d.	Date signed (i	Month, Day, Year)
		O.C.M.E. July 8, 200									8, 2007	
<b>—</b> ,		30. Name and address of pers										
1				Examiner	111 Penn Str	eet, Balt	more, N	1D 21201				
	tate	31. Date filed (Month) Pay, Ye	2°5 2007 3	2. Registrar's	12 1	mark						
Regis	trar			PHARIA	- ~ /							

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item21 per dvr 2869 7-25-07 vt
State of Maryland Pbepartment of Health and Mental Hygiene Certificate of Death

ĺ		45		1
	3. T	ime	of De	eath

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, €

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sicia	an	1. Decedent's Name (First, Middle, Last)								2. Date of I Month	Death Day		Year	3. Time of I	Death		
dic		ROGELIO	VALERA	A							JULY	19,	2	2007	0635	M	
nin	As Facility Name of the standard standa												f Death				
		GILCHRIS	ST CENT	rer/i	OWSON				TOWSON	В	BALTIMORE						
al		<ol><li>Social Security N</li></ol>	umber	6. Sex	M 000	7. Age (In	yrs. last bi		If Under 1 Year Months Days		8. Date of I	Birth Day, Yea <i>r)</i>		9. Birthpl	ace (State or try)	Foreign	
or		263-95-1	1053	130	M 2□F	5	7	Yrs.	Wionano Bays	Tiours Iviiri.	FEB.		49	Court	CUBA		
	}	Usual Residence of				140	O: -							Т.			
	_	10a. State	10b. County	/		100	. City, Tow	vn or Loc	ation					10	od. Inside Cit		
	Director	MD				В	ALTIM	ORE							1 X Yes	2 [] NO	
	Dire	10e. Street and Nu	mber						10f. Zip Code			10g. Citize	en of W	hat Coun	try?		
		3246 E.	ВАТЛТІ	MORE	ST.				21224			CU	CUBA				
	Funeral	11. Marital Status			2. Was Dec	edent Ever	in U.S.	13. W	as Decedent of	Hispanic Origin? (S can, Mexican, Puer	pecify Yes or I	No- 14		- America			
		1 🛮 Never Marr	ied 2∏ Mar	rried	1 ☐ Yes If Yes, Gi	2K No				Specify: CUI				WHIT			
	by	3 Widowed	4 Divorced	d l	Year or D	ates:		'	LEFFIES ZLINO	Specify.	JE 34. 1		<i>эреспу:</i>	******			
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ı	٦ ا	1179	<u> </u>					BRIC	CKLAYER			00	NSTI	RUCTI	ON		
	Be (	17. Father's Name	(First, Middle	, Last)						18. Mother's Na	me (First, Mida	lle, Maiden S	urname	<del>)</del>			
ı	2	ARMANDO	V. MAI	RTINI	ΞZ					ALIJAN	IDRINA I	PILOTO					
		19a. Informant's N					191	b. Mailing	Address (Stree	t and Number or R	ural Route Nur	nber, City or	Town, S	State, Zip	Code)		
ı		MICHELLI	E MYERI	ra/v.	RTEND			3246	E BAT	TIMORE ST	P. BAT	TTMORE:	. МТ	21	224		
		20a. Method of Disp		<u> </u>	CLLAND	20	0b. Place o	of Dispos	ition (Name of	T T	Date						
		1 ☑ Burial 2			emoval from				atory or other pla	i i	1/2007			City of Town State RD.			
I	1	4 □ Donation			alor (					ESUS 07/2	<u>-</u> -				21222		
l		21. Signature of Funeral Service Liction Chavis Jr. 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM.															
		2007-09 EASTERN AVE., BALTIMORE, MD 21231															
		23a. Part1. Enter the disease, or complete ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heal failure. List only one cause on each line.  Approximate Interval Between Onset and Death													veen		
		Immediate Cause (Final disease or condition											/	MM	MX.		
		resulting in death)  a. Due to (or as a consequence of):															
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	Ē	Cause (Disease or that initiated events	injury														
	Examiner	that initiated events resulting in death) Last    C  Due to (or as a consequence of):															
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J	an/Medical	IF FEMALE: 23c. If yes, outcome pf pregnancy										25	Rd Date	of delive	n/		
		in the past 12	months?			birth 2  nant at time			Ectopic pregnant Other (specify)	су		11	Mon		-	'ear	
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	띺	Part II. Other signi	ficant condit	ions conf	tributing to d	leath but no	t resultina	in the un	derlying cause o	iven in Part I.	23e. Di	d tobacco us	e contri	bute to th	e cause of de	eath?	
-	þ				3 12 0		9		, , 9			⊒Yes 2□		3 ☐ Prob	1.	Jnknown	
	Completed										1	_ 1,03		100		, included	
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	o Be	examiner? 1 ☐ Yes 2 ᡚ	<b>n</b> No	Н	ospital:	Inpatient	2 □ EB/O	utpatient	3 DOA O	her:	Home 5□Re			r (Specify	11036	Via	
	-	27. Manner of Deat		======	28a. Date	of Injury	28b.	Time of	28c. Inju			e how injury			00001	r ce	
	io	1 atural	5 Pendi	ing tigation	(Mor	nth, Day Yea	ar)	Injury		ork? ]Yes 2∐No		, , ,					
	ica	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be	28e Place	e of injury -	At home f	arm etro	et, factory, office		28f Location	(Street and	Numbo	r or Duro	I Pouto Num	hor	
	Certification:	4 Homicide	deterr	mined	build	ling, etc. (S)	pecify)	arm, oao	or, ractory, ornoc			Town, State)	Numbe	ii Oi Huia	i rioute ivaiii	DEI,	
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	edical	29a. Certifier (Check only	2 Medica	ing Phys I Examin	er: On the b	basis of exa	/ knowledg mination a	ge, death ind/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to t curred at the tin	he cause(s) a ne, date and l	and mar place, a	nner as st ind due to	ated. the cause(s	)	
	ed	one)			and mar	nner stated.									`		
	Σ	29b. Signature and	title of certific	er						ise number	~	29d. Date	signed	(Month,	Day, Year)		
		P XXX	ren	X	W				$ \cup$ $\cup$	>83C	3	0014	(4	Je	10 /		
		30. Name and add	ress of persor				(Item 23 <u>a</u> )	(Type, F	Print)	5830 anles S	. ~	(0/	NS	) >	12000		
		MANLEY	V J.		MES		n / -	701	N. Ch	anus J	T 100	130N		1	Luy		
J	te	31. Date filed (Mor	th Day, Year	t one	32	Registrar's S	Signature	A STATE OF THE PARTY OF THE PAR	50 PM 1						,		
e			1111 2	a /III	11 630	Sold 1	200	400									

Registrar

100	Physici	an	1. Decedent's Name (First, Middle, L.					IV	ate of Death	Day Year	3. Time of Death
	/Medic	al	CHANIE		ENTINE				alog I	3 2007	4
	Examin	ier :	4a. Facility Name (If not institution, gi	4.	. 6-1-		own, or Location of		1	4c. County of Dea	
٠.	Funeral		5. Social Security Number 6.		e (In yrs. last birt	hday) If Under 1		24 Hrs. 8. D	ate of Birth	9. Bir	thplace (State or Foreign
L	Director		216-32-9781 Usual Residence of Decedent	1□M 2□F	73	rs. Months	Days Hours	Min. (A	Month, Day, Ye	34 C	VA
	yland yland at		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Mar a-f sh	ctor	MD Balt	imore	F	andalls	stown				1 ☐Yes 2 No
	iff the	Director	10e. Street and Number			10f. Zip (	Code		10g.	Citizen of What Co	ountry?
	23a ust b		9408 Painted T	ree Drive	2		21133			U.S.A	
	er deg	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Decede If Yes, speci	ent of Hispanic On ify Cuban, Mexicar	gin? (Specify \ n, Puerto Ricar	res or No- n, etc.)	14. Race - Ame Black, Whi	erican Indian,
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	NO	1 □ Yes 2	No Specify:			Specify: B	lack
21215-0036	72 hours after death with the Maryland 'ratural', or items 23a or 28a-f show dical Examiner must be notified at	ted	15. Decedent's B	ducation	16a.	Decedent's Usual			16b	. Kind of Business	/Industry
215	hin 7. a. an "n Medi	ple	(Specify only highest gi	rade completed)  College (1-4or 5	i+)	(Give kind of work life. DO NOT use	k done during mos e retired)	t of working			
	filed within Hygiena. other than "	Completed	10th grade	na	,	Inspec					ckerson Co
Maryland	be fill tal H od oth even	Be	17. Father's Name (First, Middle, Las	t)			18. Mothe	er's Name (Firs	st, Middle, Maid	den Surname)	
<u>₹</u>	should that the should the should the should the should be should	은	Alonzo Lister	(Toron Drive)	401	B # - 212 - A - d - d		nie Sa			
Mai	d 2 sho		19a. Informant's Name/Relationship	,						ty or Town, State,	21133
	ges 1 and 2 it of Health if Item 27 i		Deborah Player 20a. Method of Disposition	-Daughter	20b. Place of	Disposition (Name	nted tre	ee Dri		andalls : Location - City or	
mo	Pages nent of I int: if ite		1 Burial 2 ☐ Cremation 3 decided 4 ☐ Donation 5 ☐ Other (Specific Specific			y, crematory or oti	i i	7/20/	(07 B	4-11-	to Md
Baltimore,	- 는원등		21. Signature of Funeral Service Lice		King		al Park Address of Facilit F/H Wes		U/ R	andaris	town, Md
ä	Depa Impo any In		/ Nonaige (	. Sun	10	4300 V	Wabash A	st Ave, E	altim	ore, Md	21215
4			23a. Part1. Enter the disease, or conspock, or heart failure. List only	nplications that caused y one cause on each lin	the death. Do r						Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition resulting in death)	a		now					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of						
i.	xammor	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for as	a consequence of	nf):					
	uted nsit	Examiner	Cause (Disease or injury	200 10 (01 03	a consequence (	··)·					
Ć.	execu in and ial-tra	Exal	that initiated events resulting in death) Last	c Due to (or as	a consequence of	of):					
376	Tha law requires that tha death certificate be executed to has been signed by the attending physician and baga 2 should ba detached for use as the buriat-transit	ical		d							
Box 68760,	ertifica ing ph e as tl	cian/Medical	IF FEMALE:								
B0)	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic pre	egnancy			23d. Date of de	elivery Day Year
Ö	ha de the a	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at 9⊟Unknown	time of death	5 ☐ Other (spe	ecity)				
P.0	w requires that tha d been signed by the should ba detached	h h	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying ca	use given in Part I.	. 2	23e. Did tobac	co use contribute t	o the cause of death?
or Vital Records,	quires n sign ald ba	d by	DIABETIS M	telletus:	ald	CENEBA	ROVASC	ulto	1 ☐ Yes	2☑No 3□P	robably 4 Unknown
000	s bee	Completed	ACCODENT.	STATUS	DOST	- Pul	coloce	2	24a. Was an	24b. Were a	utopsy findings available
æ	Physician: Tha law r this certificate has ral director, paga 2 s	mo	ELECTOR DAI	AETWITE	Es	22 2	Ampes		autopsy performed 1□ Yes 2□	1? death?	
İta	ilan: ertifica etor, p	Be C	25. Was case referred to medical examiner?	1 00.00		-0741		of Death (Chi		10 10	2010
7 <	Physician: r this certificanal director, I	To	1 ☐ Yes 2 ☐ No	Hospital: 1 Hopatie	ent 2 ER/Ou			ırsing Home	5 🗆 Residence	e 6 □Other (Spe	ecify)
	After t		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. 1 y Year) li		Bc. Injury at Work?		Describe how i	njury occurred	
Sic	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	oe 280 Place of init	uny - At home, fa	m, street, factory,	1 Yes 2		coation (Ctros	A a med All combast as F	Purel Pouls Museles
Division	lor A after Direction by	Certification:	4 ☐ Homicide determine		c. (Specify)	m, street, ractory,	, office	201. [	City or Town, S	tate)	lural Route Number,
	To the Hospital or Attending Phwithin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying F	hysician: To the best	of my knowledge	, death occurred a	at the time, date ar	nd place, and d	lue to the caus	e(s) and manner a	s stated.
	he Ho in 24 I he Fu pletel	Medical	(Check only 2 Medical Exa	aminer: On the basis o and manner st	t examination an ated.	d/or investigation,	in my opinion, dea	ath occurred at	the time, date	and place, and du	e to the cause(s)
	To the within 2 To the соттрые	Σ	29b. Signature and title of certifier	h. Ran	)	290.	License number		29d.	Date signed (Mon	th, Day, Year)
•	3 -V			and m	0	0	11700-		V	uly &	3 2007
	0		30. Name and address of person who	completed cause of d	eath (Item 23a) (	Type, Print)	D	NORTH	TO-SI	Mess p	TAL GENT
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	=:	( 7	W-SAUS	CON	mycs	110
s.a.	Registi	rar	mm o = 2	007	K	Super )					
DH	IMH 17 Rev 1/2	001	JULAJE	OUT PERSON	1 10	OBIONA					
						ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar		State o	f Marylan			nt of H te of L			ental Hyو ا	giene Reg. No				
0.0	hysicia		Decedent's Name (First, Mi  Emma Vazquez	ddle, Last)								2. Date of Dea Month July 2	Da	007	Year	3. Time of Death 2:50 AM M	
100 0	/Medic xamin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death											4c. County of Dealh			
2-	neral ector		5. Social Security Number 581-14-5564	6. Sex	_				Takoma 1 If Under 1 Year   If Under 24 Hi Months Days Hours Mii			8. Date of Birt (Month, Da 05/20/	v, Year) (		9. Birthp Cou/	Birthplace (State or Foreign Country)	
Maryland	led at	tor	Usual Residence of Decedent 10a. State 10b. Cou MD Mont	nty <b>cgomer</b>	•37		y, Town or Lo								1	0d. Inside City Limits 1 ☐ Yes 2 KNo	
th the	erictii	Director	10e. Street and Number	- gomer	1		.ver or		p Code				10g. Cit	izen of Wi	hat Cou	itry?	
5-0036 72 hours after death with the Maryland	d other then "natural, or teme 23s or 28er e now event, the Medical Examiner must be multified at	by Funeral	13203 Stavinsky Terrace  11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced  12. Was Deceder Armed Forces 1 1 Yes, Give Year or Dates				es? If Yes, specify Cuban, Mexican, Pue  No  1 ☑ Yes 2 □ No Specify:					Specify: • •			- Americ , White,	an Indian, etc.	
2121 d within giene.	ther then maturity int, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College  3  17. Father's Name (First, Middle, Last)			ge (1-4or 5+)  Store Owner				of working 16b. Kind of Groces  's Name (First, Middle, Maiden Sum			-				
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	er trauma		19a. Informant's Name/Relation Angel Rivera/S		e, Print)			•				Route Numbe				Code) MD 20904-	
Baltimore, permit. Peges 1 ar Department of Hea	ant: If Iten ury or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other		moval from	State	Place of Dispo cemetery, cremes esapea	natory or	other place	1		ate 25/07				wn, State Maryland	
Balt permit. Departr	any injury or o		21. Signature of Funeral Service Licensee  MOD 38 2  22. Name and Address of Facility Rapp Funeral & Cremation Servi 933 Gist Ave. Silver Spring,  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.										nd 20	910-			
Exan	dical niner	dical Ex	shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c. d.	Ce Due to At Due to Due to	rebrova (or as a conseq heroscl (or as a conseq abetis (or as a conseq	uscular uence of): .erosis uence ol): Mellit	Acc								Approximate Interval Between Onset and Death	
ath certif	detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)								23d. Date Mont		ery Day Year		
Uires that	5 6	þ	Part II. Other significant cond				ulting in the u	n the underlying cause given in Part I. 23e.					Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ※No 3 ☐ Probably 4 ☐ Unknow				
	page 2 should	Completed	Chronic Renal Failure Siezure Disorder					a			24a. Was autor perfo 1 Yes		pr de	ere auto for to co eath? Yes	psy lindings available mpletion of cause of 2 No		
	director, pag	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2∑ No		spital: XX	Inpatient 2	ER/Outpatien	nt 3 D	OA Othe			(Check only o		6 DON -	. /0	1	
ing a	Atter to funeral	Certification; To	27. Manner of Death  1 Natural 5 Per 2 Accident Inve	of Injury th, Day Year)	28b. Time of Injury	М	28c. Injury Work	4 ( ) 14(	No 2	ne 5 Resid	iow injui	y occurre	d				
te o	completely filled in by the		4 Homicide det	ermined	buildi	of Injury - At high and the state of the sta	y)		•			City or Tov	vn, State	)		il Route Number,	
To the Hospitel	e rune oletely fi	edical	29a. Certifier VACerti (Check only 2 Medic	ying Physical Examine	er: On the b	best of my kno asis of examina ner stated.	wiedge, death ition and/or in	occurred vestigation	at the time n, in my op	e, date ar pinion, dea	nd place, a ath occurre	and due to the e	date and	and man place, ar	ner as s nd due to	tated. the cause(s)	
To th withir	dwoo	Me	29b. Signature and title of the					29c. License number MD47867					29d. Date signed (Month, Day, Year)  July 23, 2007				
	∐ Sta		30. Name and down of person onex Zunig. 31. Date filed (Month, Day, Ye	a M.D.	470	e of death (Item 1 Rando egistrar's Signa	lph Rd	. #2	16, R	lockv	ille,	MD 2	0852				

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Ralph Bennett Walter Jr. 07 2007 18 5:35 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Westminster Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 1 M 2□F 213-42-4908 64 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Westminster Carroll 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Meadow Branch Rd. 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 196/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify. 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Private Sector Caretaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Bennett Walter Sr. Lurley Lucy Wilhelm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 Cassandra Walter/daughter 1100 Meadow Branch Rd.Trl#5Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 7-26-07 |Beltsville,MD 22. Name and Address of Facility 8717 Green Pastures Dr. Towson, MD 21. Signature of Funeral Service Licensee 21286 Cremation + Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lweek resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) ☐Yes 2☐No 9□Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one)

Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After this certificate

signed by the attending physician d be detached for use as the buria s after death. l in by t within 24 hours a To the Funeral C Hospital

**Physician** 

/Medical

**Examiner** 

MD

Director

Funeral

þ

Completed

Be

2

Examine

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Baltimore, Maryland 21215-0036

Completed by Physician/Medical 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Be examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier l 🜠 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier There h. Gelling 29c. License number D31660 29d. Date signed (Month, Day, Year) 07/19/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STONER AVENT WESTM WISTER MARYIMA INTOMAS K. GALUL 19

Registrar

X

31. Date filed (Month, Day, Year) JUL 2 5 2007

32 Registrar's Signature

the

State of Maryland / Department of Health and Mental Hygiene

				Cer	tificate of Death	7	Reg. No.		23525	
	Dhysisia		Decedent's Name (First, Middle, Last)			2. Date of D		Year	3. Time of Death	
	Physicia /Medic		Louise Young			Month 7	Day 22	2007	2.05 pm	
1	Examine		4a Facility Name (If not institution, give street and number) 1942						0	
			Brinton Woods Nursing			ikesuille	Lar	roll	Co	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs.	if Under 1 Year If Unde Months Days Hours	Min. B. Date of B. (Month, Dec.	irth (Pay, Year) 26, 1916	9. Birthp Coun West	lace (State or Foreign try) Virginia	
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Loc	ation				Od. Inside City Limits	
	f sho	ŏ	Maryland Carroll Syke				1 □ Yes 2 ☑ No			
	18 28 P	Director	10e. Street end Number	5 V I I	10f. Zip Code		10g. Citizen of What Country?			
	with we	<u>ā</u>	1442 Buckhorn Road		21784		USA	Wildt Godin		
	ieath iie 23	era	11. Marital Status 12. Was Decedent Ever in U,S.	13. V		rigin? (Specify Yes or N		e - Americ	an Indian,	
020	be filed within 72 hours after death with the Maryland tal Hygiane. d other than "natural", or Hems 23a or 28a-f show event, the Modical Examiner must be notified at	by Funeral	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [7] No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Or Yes, specify Cuban, Mexica ☐ Yes 2 No Specify		Specify	ack, White, etc.		
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ğ	Hygie other		17. Father's Name (First, Middle, Last)		18. Moth	er's Name (First, Middl	e, Maiden Suman	n <i>e)</i>		
<u>a</u>	should be fand Mantal I marked of umatic eve	o Be	Arthur Swisher		10	la	Huff			
Maryland	W =	-		b. Mailin	g Address (Street and Numb			State, Zip	Code)	
	D = 7 = 2		James R. Young / Son 2	164	Tulsa Road S	vkesville.	Marvland	1 2178	34	
ā,	- 4 5 5		20a. Method of Disposition 20b. Place	of Dispos	ition (Name of atory or other place)	Date	20c. Location			
Baltimore,	permit. Pages Department of I Important: if ite any injury or of pnce.		1 M Burial 2 Li Cremation 3 Li Hemoval from State	•	e Mem. PArk	7/26/07	Graftor	n Was	st Virgini	
	artm ortar inju	ł	21. Signature of Foneral Septice Licensee		Name and Address of Facil				rk Road	
ñ	Ded Imp		13-11-11-11	D	usk Tayloon Cu	novel Home				
		$\dashv$	23a. Pert 1. Enter the disease, or comblications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	uck Towson Fu	cardiac or respiratory	, ITIC. I OW	vson,	Approximate	
£;	Physician /Medical Examiner	Examiner	Immediate Ceuse (Final disease or condition resulting in death)  a. Julian Due to (or as/a	1	ativo Delloi Jence of):	itia				
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5	d by the letacher	Physician	Ischause Heart Distance	denying cause given in Fait		23b. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unku				
ords	S 50 3	Completed by				24a. Wa	s an autopsy formed?	ava	re autopsy findings illable prior to appletion of cause death?	
Ē	The law ata has page 2	E O				10	Yos 2010	1	Yes 2 No	
<u>E</u>	certificata	De l	25. Was case referred to medical		26. Plac	e of Death (Check only	one)	1		
5	S wid	0	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/O	•	3□ DOA Other: 4 1 1	ursing Home 5□ Res	idence 6 □Oth		)	
0	Attending P r death. octor: After by the funer	ation		Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐		how injury occur	190		
=	al or Atten s after deat il Director: sd in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, f building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending Physician 24 hours after death.  To the Funeral Director: After this completaly filled in by the funeral	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledg 2 Medical Examiner on the basis of examination at and manner stated.	e, death	occurred at the time, date ar estigation, in my opinion, dea	nd place, and due to the ath occurred at the time	cause(s) and ma , date and place,	anner as st and due to	ated. the cause(s)	
	withir To the comp		29b. Signature and title of certifier		29c. License number	. (	29d. Date signer	d (Month, l	Day, Year)	
			1 Latech Tu		12080	)6	7/2	4/6	1+	
6	T		30. Name and rochess of person who completed cause of death (Item 23a)	(Type, P	rint) 102/1000	GBARTY	RO EL	Dons	BURG	
Ì	State Registra		31. Date filed (Month, Pay, Year) 32. Poistrar's Signature	1	anti o					

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar				Ce	rtificate o	ı Deam			Reg. No.			
Diversitati		1. Decedent's Name (First, M.	liddle, Last)							2. Date of De		Year	3. Time of Death	
Physicia /Medic		I MARGARITA WALDURGA DOIWINICK								JUL	14 2	2007 Year	7:08 A	
Examin	A	4a. Facility Name (If not institu	NAVAL M	IEDICAI	CENT			HESDA				MONTG	OMERY	
Funeral Director		5. Social Security Number  054-58-0147  Usual Residence of Decedent		1 2 F 7	Age (In yrs.	last birthday Yrs.	Months Day		Min.	8. Date of Bir (Month, Da 05/28	v Year	6 Ger	rthplace (State or Fore lountry) many	
show show	ō	10a. State 10b. Cou	unty	-		y, Town or L							10d. Inside City Lim 1 ☐ Yes 2X	
28a-f	ect	Virgina   Prince William   Woodbridge   10e. Street and Number						9		· · · · · · · · · · · · · · · · · · ·	10a. Citiz	g. Citizen of What Country?		
23a or 3	<b>Funeral Director</b>	5614 Northton	n Court	:		10f. Zip Code 22193					United States			
permit. Tages I and 2 should be inter which 7 z hours after beain with the maryland Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2☑ ! 3 □ Widowed 4 □ Divor	Married	. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	. No	.S. 13.	. Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☑ N			ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi Specify:		
"natura	Completed	15. Dece (Specify only hi	edent's Educat ighest grade c	tion completed)		16a. Dece	edent's Usual Occ e kind of work do DO NOT use ret	cupation ne during mo	st of work	ing	16b. Kir	nd of Business	s/Industry	
than the Me	Ĕ	Elementary/Secondary (0-1 12	12)	College (1-4	for 5+)		maker	ii eu j			House	sehold		
Hygi Hygi other ent, ti		17. Father's Name (First, Mid	Idle, Last)			110111		18. Moth	ner's Name	(First, Middle				
hental rked c	To Be	Bernhard Born	re					Agne	es Be	hrens				
and N	-	19a. Informant's Name/Relati									r Town, State, Zip Code)			
n 27 i		John Botwinio	ck - Hu	sband									ia 22193	
ment of He tant: If iten jury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	er ( <i>Specify</i> )	noval from Si	tate	emetery, cie antico	position (Name of ematory or other positional National	1 Ceme	etery		Tria		Virginia	
Depart Import any In		21. Signatur of Funeral Sen	vice Licensee	Car	1		22. Name and Add							
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. NON SMALL CELL LUNG CANCER  Due to (or as a consequence of):										Approximate Interval Betweer Onset and Deat		
10 N/S														
ate be executed hysician and he burial-transit	lical Examiner	Sequentially list conditions, if any least to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b c		r as a conseq									
sertificate be ding physicia se as the bur	/Medical	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 XNo 9 Unknown	b c d 23c	Due to (o	r as a conseq ome pf pregna th 2 □ Feta nt at time of c	uence of): ancy al death 3	□Ectopic pregna					23d. Date of d Month		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Bathmore Washington Medical Contr Glen Burnie If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number Age (In vrs. last birthdav) 6 Sex Year) **Funeral** Days 1 □ M 2 □ 212-03-7336 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1017 CAYER DR. APT: 403 2106 1.5.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Drock Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 3 Widowed 4 □ Divorced DAITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISLANDIR-SARROWS POINT, MD. ZIZZZ 734 MillERS AUREL WHITE, NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 7-21-07 5 ☐ Other (Specify) 4 ☐ Donation CREMATORY 22. Name and Address of Facility 21. Signature Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 23a. Part1. Enter the disease of complications the shock, or heart failure List only one cause of caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) en 62871 YF **Physician** /Medical Due to (or as a consequence of): Examiner AIZINO MYDVATA Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consequence off Physician/Medical Examiner ANEMIX The law requires that the death certificate be executed the burial-transit Que to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician FIBALLATION attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29b. Signature itle of certifie

within 24 hours after death.

To the Funeral Director: Completely filled in by the f

State

31. Date filed (Mont)

30. Name and address of person who complete

2007

29d. Date signed (Month, Day, Year)

ed cause of death (item 23a) (Type, Print) emue 32 Registrar's Signature

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				State of Manuard / Departm		-	_			
				1- State of Maryland / Departm	ent of Health and rate of Death		eg. No.			
		Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death _Month		3. Time of Death		
		Physici /Medio		Ann Belfield Bartlett		/ ]	11 2007	12:20 PM		
U		Examir	ier		City, Town, or Location of Death		4c. County of Death			
		- Francis		Atlantic General Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Berlin nder 1 Year   If Under 24 Hrs.	8. Date of Birth	Worceste	pplace (State or Foreign		
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QO		death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D Armed Forces? 13. Was D	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, White			
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000 - 11-10-		s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. Item 27 is marked other than "nature other traumatic event, Ital Medical	ř		lress <i>(Street and Number or Ru</i> h St. Unit 101		•			
20	Č.	of Hez		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  cemetery, crematory	(Name of or other place)	Date 2	20c. Location - City or	Town, State		
_	Baltimore,	permit. Pages Department of t Important: if its any injury or o		1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	en Crem. 7/1 se and Address of Facility Th	2/2007	Frankford			
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$\subseteq$			<	23a Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Anset and Death		
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579	Is, P.	ires that lhe signed by th d be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.		pacco use contribute to	the cause of death?		
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#	S C	ath. r: After te funer	lon	27. Manner of Death  Natural 5 □ Pending (Month, Day Yeer)  2 □ Accident investigation  28a. Date of Injury (Month, Day Yeer)  Injury  M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	280. Describe no	w injury occurred			
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5a		To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this cartificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occur of the basis of examination and/or investigation and manner stated.	rred at the time, date and place ation, in my opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)		
		omple	Med	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Monti	n, Day, Year)		
		- s - ō		Mount	D2876	9	2/12/0	<b>أ</b>		
	8	941		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-£1141	F.	to III 1	De 19944		
	0	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	man vyung	1 mil	on I pour	, , = \ [ , , , , ]		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend 28e, perME, g870, 8/16/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 12:22 p<sub>M</sub> Lloyd Wilbert Brown July 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 16500 Oak Hill Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Yrs. 579-05-2564 Director 87 August 6, 1919 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is an Injury or other traumatic event, the Medical Examiner must be Is an Injury or other traumatic event, the Medical Examiner must be Is an Injury or other traumatic event. 16500 Oak Hill Road 20905 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: ↓ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: 2 White 3 Widowed 4 Divorced WWIT Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Legal Services Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Mortimer D. Brown Rosa Elizabeth Strouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16500 Oak Hill Road, Silver Spring, Maryland 20905 Edna D. Brown - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7/5/2007 4 □ Donation 5 □ Other (Specify) Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licen Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dis Immediate Crise (Final disease or condition resulting in death) **Physician** Gun Shot Wound To Head /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ∑Yes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Natural Gun Shot To Head 1 ☐ Yes 2 No 7/1/2007 12:22 2 Accident

sician and burial-trans Division or Vital Records, P.O. Box 68760 attending physician for use as the buria pe been signed by the should be detached certificate To the Hospital or Attending Phys
within 24 hours after death.

To the Funeral Lirector: After this
completely filled in by the funeral dir

with the Maryland

3altimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State

3 N Suicide

(Check of one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

4 Homicide

32. gistrar's Signature

Barn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D15236

28f. Location (Street and Number or Rural Boute Number, City or Town, State) 16500 Oak H111 Road

29d. Date signed (Month, Day, Year)

July 3, 2007

Silver Spring, Maryland 20905

6 Could not be determined

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Clifford Bazel, Sr. 4:48 p<sup>M</sup> July 2007 8 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery Year If Under 2 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min Months Hours 1 X M 2 □ F Director 578-68-2929 58 January 25,1949 Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11538 February Circle, Apt. 203 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No A Q Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Technician Automotive Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel David Bazel 2 Anna May Goins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mattie R. Bazel - Spouse 11538 February Circle, Apt. 203, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/14/2007 and Menorah Gardens Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Nanc 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Bactremia burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 the attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diffuse Motor Weakness 1 Yes 2 No 3 Probably 4 € Unknown Completed Renal Insufficiency 24a. Was an Were autopsy findings available prior to completion of cause of performed' death? 1 ☐ Yes 2□ No Division or Vital 1□ Yes 2K No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☒ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 X Natural 1 TYes 2 TNo 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifie 29c. License number

10

State Registrar

Sirak Hagos Lemma, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature JUL 1 1 2007

enne-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0065069

29d. Date signed (Month, Day, Year)

July 9, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 26 per phy State of Maryland / Department of Health and Mental Hygiene, aaco hlth dept 7/10/07 dlw 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 20 W1 9:05 aff 7/8/2007 ILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 4406 Claybrooke Dr. Lothian If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number Year Hours **Funeral** Months Days M 2□F 5/4/1929 PA 78 Director 216-22-1276 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Deale MD Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20751 USA 5881 Rock Hold Creek Rd. by Funeral death 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married XX Married White 1 ☐ Yes ŽŽ No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) 12 College (1-4or 5+) Boats & Automotive Owner Operator . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 is marked other ti jury or other traumatic event, th other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alma Anthony Charles A. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. Wife 5881 Rock Hold Creek Rd. Deale, MD 20751 Marzie Ann Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 7/12/2007 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Fungral Service Lic Oal 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 317 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) len Examiner En Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed iated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy Dav Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an tackcard 25. Was case referred to medical examiner? dani Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 1 ☐ Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? residence 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 ☐ Pending investigation 1 TYes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Chief Medical Officer D 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, M.D., Hospice of the Chesapeake, 445 Defense Highway, Annapolis, MD 21401

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 0 2007

ORIGINAL

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, Date of Death 3. Time of Death **Physician** Month 2237 M BISHOP 0 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 712 Dividing Creek Road Arnold Anne Arundel 5. Social Security Number Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 10 M 2□ F Hours New York Yrs Director 054-38-5977 59 Aug 18, 1947 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show "natural", or items 23a or 28a-f shov idical Exaπiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 Dividing Creek Road 21012 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced d other than "natura event, the Medical F Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Vice President Development permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Douglas Bishop JoAnn Hammersley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan McDonough Bishop / Wife 712 Dividing Creek Road Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Crematory 7/10/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 Mont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Examir physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ te has been signated age 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2□ No 1□ Yes 2 No certifica 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home Hospital 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: /
filled in by the fi 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral I 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner state within 2, To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who ed cause of death (Item 23a) (Type, Print

State Registrar

31. Date filed (Month, Day, Year) JUL 1 0 2007

MICHAEL

trar's Signature

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NSE HGHWAY

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Stateof Maryland / Department of Mealth and Mental Hydiene:

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Baltimore,	permit. Pages Department of Importent: If it any injury or c		21. Signature of F	uneral Service Lice	ensee			. Name and Add	ress of Facility	Crouch F			
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7	/Medical		resulting in death)		Due to (or a	a consequ	-	- tracks				-	1110
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	of the	Me	29b. Signature and	d title of certifier	11			29c. Lice	nse number		29d. Da	te signed (Month,	Day, Year)
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	Registi			JUN 13	2007	we.	N 19	Ser.					

#284-F

Division or Vital Records, P.O. Box 68760.

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. the

CHANDU VEMURI

29b. Signature and title of certifier

6 Could not be

2 Accident

3□ Suicide

29a. Certifier

Medical

State

Registrar

4 ☐ Homicide

(Check only one)

9000 Rockville Pike, Bethesda, Maryland 20892

Begistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

JUL 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1 ☐ Yes 2 ☐ No

MI 4301083695

1 🗹 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

07,10,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Florence Carleton 12:30 <sup>p M</sup> Jean /Medical 2007 July 6, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3310 N. Leisure World Blvd,. #1014 Silver Spring Year If Under 24 Hrs. 8. Days Hours Min. Montgomery

9. Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2√2 F Yrs **Director** 141-09-9268 Dec. 31. 1916 New Jersey Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 N. Leisure World Blvd., #1014 20906 filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 🖾 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other tha any injury or other traumatic event, the i once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Stephen Fowler ပ Florence Elaine Crowley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arthur M. Carleton/ Husband 3310 N. Leisure World Blvd., #1014, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 12, 20c. Location - City or Town, State 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. . Ken Skile 500 University Blvd, W., Silver Spring. MD 20901 23a. Aart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Failure To Thrive /Medical Due to (or as a consequence of) Examiner Advanced Age Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Wasting Syndrome and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 or Attending Physician; The law requires that the death certificate be Physician/Medical Cerebral Arteriosclerosis IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea'
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

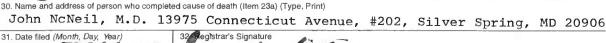
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2/1/No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home SAResidence 6 Other (Specify) ျှ 1 ☐ Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural s atter dea...ral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 \*\*Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

within 24 hours a To the Funeral I

State Registrar

31. Date filed (Month, Day, Year) JUL 1 1 2007

29b. Signature and title of certifier



246584

29d. Date signed (Month, Day, Year)

July 09,2007

		•	1 - State of Maryland / De State of Maryland / De C	epartment of Health and Pertificate of Death	na Mental H	lygiene Reg. No	0.000	2354,)		
	Physici		1. Decedent's Name (First, Middle, Last)  ALLEN S. CRAWFORD		2. Date of Month JUNE		200°7°	3. Time of Death 10:30 PM		
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Apex Nursing Center	4b. City, Town, or Location of E	Death		. County of Deat			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24	Hrs 8 Date of	Birth Day, Year	Q Rint	hplace (State or Foreign untry)		
	Director		Usual Residence of Decedent		Apr.	3,19	144 Lou	iiŝiana		
	Marylan a-f show ified at	ctor	10a. State 10b. County 10c. City, Town of Montgomery	Olney				10d. Inside City Limits 1 <b>X</b> Yes 2 No		
	3a or 28 st be not	al Director	10e. Street and Number 2921 McGee Way	10f. Zip Code 20832		10g. Ci	tizen of What Co			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes Yes No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F     □ Yes 2 No Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: B1	e, etc.		
Maryland 21215-0036	in 72 ho n "natu Aedloal	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation five kind of work done during most of ie. DO NOT use retired)	of working	16b. k	Kind of Business/	Industry		
212	ed with lygiene. ner thar it, the N		22011	ecurity Guard	Name (First Adid	Security Co				
land	ild be fil lental H <b>ked o</b> th Ic even	To Be	17. Father's Name (First, Middle, Last)  Thomas Crawford	18. Mothers	Lilly	ne, maidei	1 Surname)			
<b>Jary</b>	2 shour and M	-		ailing Address (Street and Number of				Zip Code)		
	s 1 and of Healti item 27 other t		20a. Method of Disposition 20b. Place of Disposition	sposition (Name of crematory or other place)	Date Date		ocation - City or	Town, State		
Baltimore,	it. Page rtment c rtant: If njury or		A Buriai 2 Cremation 3 Hemoval noni State	morial Cem 7	/13/07	San	dy Spr	ing, MD		
Ba	permi Depar Impor any ir		EME Service Library				, MD 20850			
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heardfailure. List only one cause on each line.				Approximate Interval Between Onset and Death			
	/Medical		disease or condition resulting in death)  a.   OCCIUSIVE  Due to (or as a consequence of):	Peripheral Vas	scular :	uise	ase			
A.	Examiner	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				2 weeks			
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):					<del></del>		
68760,	ificate be executed g physician and as the burial-transit	edical E	d							
		Med	IF FEMALE: 220 If you guttome of groups of							
.O. Box	ires that the death certifi signed by the attending I I be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □ Ectopic pregnancy 5 □ Other (specify)		-	23d. Date of del Month	Day Year		
rds, P.	quires tha n signed I ıld be det	by	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.		id tobacco □ Yes 2		o the cause of death? robably 4		
Division or Vital Records,	: The law requires that the icate has been signed by th ; page 2 should be detache	Completed			24a. W au pe 1 Ye	itopsy erformed?	prior to o	utopsy findings available completion of cause of 2 No		
Z Vit	yslciar is certif director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 25 No	104	if Death <i>(Check on</i> sing Home 5 ☐ R		6 □Other (Spe	cifv)		
o uc	Attending Physician: r death. ector: After this certifice by the funeral director, i		27. Manner of Death  1 X Natural 5 □ Pending (Month, Day Year)  28b. Tim (Month, Day Year)	e of 28c. Injury at	28d. Descri		ury occurred			
Division	Dir Dir	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)		28f. Locatio	n (Street a Town, Stai	nd Number or Ru te)	ural Route Number,		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29d. D										
		Me	29b. Signature and title of certifier	29c. License number D09834			ate signed (Mont	h, Day, Year)		
	3		30. Name and address of person who completed cause of death (Item 23a) (Ty Barry N. Rosenbaum 3720 Far		engina+	1 1	<u> </u>	95		
	Sta		21 Date filed (Month Day, Year) 32 Agaistrar's Signature			J.1 /				
	Regist	ar	1111 1 1 2007 A							

07-05430 Victor Daniel

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ACION Danies	1- For State Cert	ificate of Death	Reg. No.
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year 1420 bro
Medical Examiner	Victor Christopher Daniel	IV	July 15, 2007 1430 hrs
	4a. Facility Name (if not institution, give street and number) 5505 Forest Park Avenue	4b. City, Town, or Location of Death Gwynn Oak	Baltimore County
	5. Social Security Number 6. Sex 7. Age (In yrs. Ia:		8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	577 <b>-</b> 08-2027 1xm 2F	40 Yrs. Months Days Hours Min.	Sep. 16, 1966 Foreign Washington D.C.
any	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Fown or Location	10d. Inside City Limits
<b>*</b> ,	MD Baltimore Ba	ltimore	1 X Yes 2 No
faryland  28a-f show Latonce. ector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3a or otified	5505 West Forest Park Ave.	21207	U.S.
e death with the Maryland or items 23a or 28a-f shomust be notified at once.	11. Marital Status 1 X Never Married 2 Married Armed Forces?	<ol> <li>13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.) White, etc.
	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	African- Specify: American
urs aft tural" amine	15 Decodors's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of w	ork done 16b. Kind of Business/Industry
0036 within 72 hour giene. her than "natu .Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retir	ed)
within ene.	9	Disabled 148 Methor's Name	(First, Middle, Maiden Surname)
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)  Victor Christopher Daniel III	Ivy Har	
2121: ould be fill d Mental II s marked lic event,	19a. Informant's Name/Relationship (Type, Print )		tural Route Number, City or Town, State, Zip Code)
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by 1	Beverly A. Chappelle / Sister	7600 Stanmore Drive,	Beltsville, MD 20705
re, legit and free legit transfer tra	20a, Method of Disposition 20b. F	Place of Disposition (Name of cemetery, rematory or other place)	Date 200. Location - City or Town, State
imo Pages nent o ant: l	4 Donation 5 Other Specify: Li:	ncoln Memorial July 2	23, 2007 Suitland, MD
Baltimore, MD 21215-005 Baltimore, MD 21215-005 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene, Important: If item 27 is marked other ti injury or other traumatic event, the Med	21. Signature of Funeral Service Licensee		Guire Funeral Service, Inc. N.W. Washington, D.C. 20012
Physician	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as cardiac of	r respiratory arrest, shock, or heart Approximate Interval Between Onset and
M. dical	failure. List only one cause on each(line   Immediate Cause (Final disease   a. Mixed drug intoxi		Death
xaminer	or condition resulting in death)  Due to (or as a consequence of		
L.	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of	·)·	
nine	Cause. Enter Underlying Cause (Dispass or injury that initiated		
red misit	events resulting in death) Last Due to (or as a consequence of	f):	
execular and an and all - tra	X UNPENDED 4AMENDED 280-E DO	erME,g870, 8/22/07 TT	
'60, rate be physicia he buria	IF FEMALE: 23c. If yes, outcome of preg		23d. Date of delivery
Sox 687 leath certific e attending p for use as th	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregnate  ath 5 Other (Specify)	ancy Month Day Year
the death certification by the attending check for use as I Physician/	1 Yes 2 No 9 Unknown g Unknown	5 Other (Specify)	
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for a		esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 ✔ Unknown
ords, P.O. I aw requires that the as been signed by to 2 should be detached by PP poleted by PP poleted by PP			24a. Was an 24b. Were autopsy findings available
tal Records, cian: The law require certificate has been signeteror, page 2 should be Be Completed			autopsy prior to completion of cause of death?
Recc The lav			1 Yes 2 No 1 Yes 2 No
	I overminer?	26.Place of Death (Check	only one) ng Home 5 Residence 6 ✔ Other: Scene
Division of Vital Records, tall or Attending Physician: The law require and or Attending Physician: The law require and priceon: After this certificate has been sited in by the funeral director, page 2 should be refification: To Be Completed	1 V Yes 2 No The Hard Park 2	ER/Outpatient 3 DOA Nursi  28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
on of \and nding Plu; th :: After tl e funeral	1 Natural 5 Pending (Month, Day, Year) Fnd 7/15/2007	Fnd 2:15 pm 1 Yes 2 No	unk
risior r Attend er death irector: a by the	2 Accident Investigation 3 Suicide 6 X Could not be	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of spiral or Attending bours after death meral Director: After filled in by the fune Certification:	4 Homicide determined (Specify) other		5505 Forest Park Ave. Baltimore MD
		ge, death occurred at the time, date and place, an ind/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
To the Ho within 24 To the Fu completed	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	71111	O.C.M.E.	July 16, 2007
	30. Name and address of person who completed cause of death (Iten	1 23a)	
	Zabiullah Ali, M.D. Assistant Medical Examiner		1201
Stat	31. Date filed (Month, Pay Year) 2007 32 Registrar's Signat	to aparte	DOME

DHMH 17 Rev 1/2001 OCME 2006

	State of Maryl	and / Department of Health and	Mental Hygiene	
1 - State Registrar	,	Certificate of Death	Reg. No.	
1. Decedent's N	ame (First, Middle, Last)		2. Date of Death	3. Time of Death
Marie N	Marthe Francoise	Durelli	Month Day Year July 7, 2007	11:45 a

			Registrar	Cer	tificate of L	Jeath	Re	eg. No.				
	Physicia /Medic	-	1. Decedent's Name (First, Middle, Last) Marie Marthe Francoise	Durel	li		2. Date of Deat Month July	7, 2007	3. Time of Death  11:45 a M			
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  4 Pinehurst Circle  5. Social Security Number  359-24-9779  6. Sex 7. Age (In yrs 1 In M 2 I	. last birthday) Yrs.	4b. City, Town, or  Chevy  If Under 1 Year  Months Days	Chase	8. Date of Birth (Month, Day, April 30	Year) 9. Bir	gomery rthplace (State or Foreign ountry)			
"0	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	Maryland Montgomery  10e. Street and Number  4 Pinehurst Circle  11. Marital Status  1 Never Married 2 Married  11 Yes 2 No	J.S. 13. \	cation  Cyy Chase 10f. Zip Code 2081  Was Decedent of His If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto		0g. Citizen of What C US. 14. Race - Am Black, Whi	A erican Indian, ite, etc.			
and 21215-0036	be filed within 72 hours a ntal Hygiene. od other than "natural", o event, the Medical Exam	Be Completed by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  5.  17. Father's Name (First, Middle, Last)	16a. Deced	dent's Usual Occupation kind of work done during most of working DO NOT use retired)  Homemaker  18. Mother's Name (First, Middle							
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.	To	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	Place of Dispo cemetery, crer te of H	5509 Utah esition (Name of matory or other place Heaven Cen Prancerd Address	Avenue,  of Officery  rsity Blue	er, City or Town, State, Zip Code) Shington, DC 20015 20c. Location - City or Town, State Silver Spring, Maryla 11 Home Inc. Silver Spring, MD 209					
68760,	certificate be executed had provided and multiple and multiple as the burial-transit	lical Examiner	23a. Part1. Puter the disease, or complications that caused the deal shock, owneart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Uncertifying Cause (Disease or injury that initiated events resulting in death) Last  Cardiac Ar  Due to (or as a conse or injury that initiated events resulting in death) Last  Cardiac Ar  Due to (or as a conse or injury that initiated events resulting in death) Last  List only one cause on each line.	rest quence of): rtery C quence of): ellitus quence of):	Disease	g, such as cardiac	or respiratory arro	est,	Approximate Interval Between Onset and Death  10 Years			
P.O. Box	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as to	leted by Physician/Medi	Completed by Physician/Medical	leted by Physician/Medi	leted by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions contributing to death but not re	tal death 3 cdeath 5 cdeath 5 cdeath 5 cdeath 5 cdeath 5 cdeath 5 cdeath 5 cdeath 3			23e. Did tol 1	es 2√xNo 3∏F	elivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available
Division or Vital Records,	or Attending Physiclan: ifter death. Director: After this certifica in by the funeral director. p	Certification: To Be Comp	25. Was case referred to medical examiner?  1  Yes 2 No	ER/Outpatier  28b. Time o Injury  home, farm, str	of 28c. Injun Work M 1 🗆	er: 4 ☐ Nursing H	th (Check only on ome 5 Reside 28d. Describe ho	sy prior to death? 2 □ No 1 □ Ye  lee)  lence 6 □ Other (Sp  low injury occurred  treet and Number or it.	completion of cause of us 2 □ No necify)			
	To the Hospital within 24 hours a To the Funeral   completely filled	Medical Co	29a. Certifier (Check only one)  29b. Signature and title of certifier  Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier  May Deumlin W	nation and/or in	29c. License	pinion, death occu e number	irred at the time, o	date and place, and do	ue to the cause(s)			
,	O		30. Name and address of person who completed cause of death (Ite	em 23a) (Type,	Print)	#1400, (	Chevy Cha	ase, MD 20	1y 9, 2007 815			
	Sta Registi	State istrar 31. Date filed (Month, Day, Year) 32 legistrar's Signature 1 1 2007										

			State of Maryl 1 - State Amend Items 25,27,28a-1	and/Depart we Cel	2869,077 Micate of L	<b>20/07dfib</b> Death	ientai Hy	giene Reg. No	e Onni	o a on a
0			Decedent's Name (First, Middle, Last)				2. Date of De			3. Time of Death
	Physicia	_	David James Dunn				Month July	4,	2007 Year	8:55p M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	oury	40	. County of Death	-
			Frederick Memorial Hospit	al	Frede	rick			Frederick	
	Funeral		5. Social Security Number 6. Sex 7. Age (In )	yrs. last birthday)	if Under 1 Year Months Days		8. Date of Bi (Month, D	rth	l 9. Birthol	ace (State or Foreign
ш	Director		126-28-7709 1XM 2□F	70 Yrs.	Moriano Bayo	Tiodio Time	MAY 7		7	KLYN, NY
	pu ,	1	Usual Residence of Decedent         10a. State         10b. County         10c.	. City, Town or Lo	scation				110	Od. Inside City Limits
	anyla shov	5		WAYNESBO					1	1 ☑ Yes 2 ☐ No
	he M	Director	PA FRANKLIN  10e. Street and Number	WAINEDDO	10f. Zip Code			10a C	itizen of What Coun	trv?
	a or	급			17268				S.A.	.,,
	eath ns 23 musi	Funeral	55 BROWN ST.  11. Marital Status  12. Was Decedent Ever in	in U.S. 13.		spanic Origin? (Sp	ecify Yes or N		14. Race - America	an Indian,
	iter d	ű	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White,	
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examiner must be notified at	by	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 55	-59	1 ☐ Yes 2 ☒ No	Specify:			Specify: WHI	TE
Ö	2 hou	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupa		ina	16b. l	Kind of Business/Ind	lustry
215	within 7 iene. • than "n the Medl	ble	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	MANAGEM	0	FE	DERAL GOV	ERNMENT
21;	d wit	Š	12	DIR.	OF PERSO	MAL & LAB	OR			
	e filed al Hygi d other event, t	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name			ŕ	T C
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	၉	GROVER C.						ORAN CURL	
a	2 sho and is mi		19a. Informant's Name/Relationship (Type. Print)	!					or Town, State, Zip	Code)
	es 1 and 2 of Health item 27 i		KATHLEEN M. DUNN	55 Ob. Place of Dispo	BROWN ST					Ot-1-
Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 ত Cremation 3 ☐ Removal from State	cemetery, cre	matory or other plac	re)	Date		ocation - City or To	
Ë	permit. Pag Department Important: I any Injury o once.		4 ☐ DonAtion 5 ☐ Other (Specify)		JRG CREMA'		9/07	SM	ITHSBURG,	MD.
3alt	permit Depart Impor any In once.		21. Signature of Funeral Service Licensee	2	2. Name and Addres				ERAL HOME	
	70 = 40	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								27 Approximate
в	shr xk, or heart failure. List only one cause on each line.									Interval Between Onset and Death
Physician Immediate Cause (Final dishase or condition resulter) in death)										
	/Medical Examiner		Due to (or as a cor	nsequence of):						
b		-	Sequentially list conditions, if any, leading to immediate Due to (or as a cor	rsequence of):			, ,		-	
	ted	nin	cause. Enter Underlying Cause (Disease or injury				11/	W		
_ In	fficate be executed g physician and ts the bunal-transit	Examiner	that initiated events c	nsequence of):			EDICAL EXA	MALE	).	
68760,	siciar siciar	al	d							
68	ificate g phy as the	edical	Cause. Effet Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  CEMPECATION APPROVED BY MEDICAL EXAMINETS  D.  23d. Date of de							
Box	leath certif attending I for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐		Testania programa	,			23d. Date of delive	ery
m.	death e atten	icia	in the past 12 months?  4 Pregnant at time		□Ectopic pregnancy □ Other <i>(specify)</i>				Month	Day Year
P.0	t the by the	hys	9 ☐ Unknown 9 ☐ Unknown	_						
	w requires that the deben signed by the should be detached		Part II. Other significant conditions contributing to death but no			en in Part I.	23e. Did	tobacco	use contribute to the	
ğ	aquire en siç ould b	ba	My clodysplashic >	mas	rm e		1	] Yes	2 <del>□ N</del> o 3 □ Prob	oabiy 4 Unknown
S	law re as be	plet	Cosmany Arteny a	disecu	18		24a. Wa	s an opsy	24b. Were auto	psy findings available mpletion of cause of
æ	و تـ و	performed? death?  1 Yes 2 No  25. Was case referred to medical  26. Place of Death (Check only one)								
ital	sician: Th certificate rector, pag									
r <		examiner?  o 1 Twes 2 Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 28a. Date of Injury (Month, Day Year)  1 Twest 2 Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28b. Time of Injury Work?  28b. Time of Injury Work?								
0 U	ng Pl fter th									
Sio	endii eath. or: A	Unknown Unknown 1   Yes 2x No Probable fall								
Division or Vital Records,	27. Manner of Death    Second   Death								al Route Number,	
	oital ours at peral Dilled	Ce		. kanuladan daa	th cooursed at the ti					
	Hosp 24 ho Fune Fune	fica	29a. Certifier 1 ✓ Certifying Physician: To the best of my (Check only one) 2 ☐ Medical Examiner: On the basis of examiner one) and manner stated.							
. \	To the Hospital or Attending Physical within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	29b. Signature and title of certifier		29c. Licens	e number		29d. D	ate signed (Month,	Day, Year)
	FSF0		1 The MA		Doc	604117		7	15-1200	7
			30. Name and address of person who completed cause of death	(Item 23a) (Type	. Print)	160417 nga1		•	1-1	2124
			Hemen shah, 650	Thomas	e Joh	ngas	Dr. F	rea	Perica	MINZ
		ite	31. Date filed (Month, Day, Year) 32. Registrar's	Signature						
	Regist	rar	JUL 2 0 2007 Libert J.	GOBALL	-0					

			State of Marylar				lental Hy	giene	1	2701.		
			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of L	Jeath	2. Date of De	Reg. No.		3. Time of Death		
Phys	sicia edic	-	Linda D. E	lliot	t		July	16,200	Year <b>7</b>	3:40 A <sup>M</sup>		
	mine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of		0.10		
Fune: Direct			Gilchrist Center for Hospi 5. Social Security Number 6. Sex 1 M 2 XF	. last birthday) Yrs.	TOWSOR If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birthp	lace (State or Foreign try)		
pu ,			Usual Residence of Decedent				March	28,195				
laryia show ed at		'n		ity, Town or Lo	Parkv	4110			11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No		
the N 28a-1		Director	Maryland Baltimore  10e. Street and Number		10f. Zip Code	1116		10g. Citizen of W	hat Coun	itry?		
h with 23a ol st be		a	2815 Onyx Road			21234		II C A				
Signal yidalid ZIZIS-UUSO  sges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If ifew ZY is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		y Funeral	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in Carried Armed Forces?  1 Yes, Sive		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ▼☐ No	spanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		- America k, White, k	etc.		
72 hours natural",		Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Bus				
within within ane.		ig m	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired	)						
filed v Hygie other t		ပ္ပို	12th 17. Father's Name ( <i>First, Middle, Last</i> )	HOI	memaker 	18. Mother's Name	e (First, Middle,	Own Hor Maiden Surname				
Jali Jid be Jental Aental rked o		To Be	Richard M.	Watts		Dalla	s Hill					
VICE Should be filed we hand Mental Hygie VIS marked other traumatic event. the			19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a				State, Zip	Code)		
tem 27			Larry R. Watts, Sr./Brother  20a. Method of Disposition  1 Rurial 2 Secremation 3 Removal from State	2815 Place of Dispo	Onyx Ro	ad Balt	imore,	Marylar 20c. Location - G	ad 2 City or To	.1234 wn, State		
Pages nent of lint: If ite			Tabana 2 Scientation 5 aniemova nom state			!				Maryland		
permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr	once.		21. Signature of Funeral Service Licensee  Michael P. Manuello							Chapel, P. Vland2121		
			23a. Part1. Enter the disease, or complimions that caused the dea shock, or heart failure. List only one cause on each line.							Approximate Interval Between		
Physicia	-		Immediate Cause (Final disease or condition	tatic	colon (	Cancer				Onset and Death  Jeau		
/Medic Examin			resulting in death)  Due to (or as a conse	quence of):					(	9		
4 1		Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	quence of):					-			
p-cuted nd ransit		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
icate be executed physician and sthe burial-transit		E E	resulting in death) Last Due to (or as a conser	quence of):								
ficate physical physi		edical	d									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.  To the Funeral Director: After this certificate has been signed by the attending physician and competely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	∃Ectopic pregnancy ∃ Other <i>(sp</i> ec <i>ify)</i>			23d. Date Mor	e of delive nth	ery Day Year		
that the ed by detacl			Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contri	ibute to th	ne cause of death?		
requires t een signe		d by					1 🗆 '	Yes 2 No	3 ☐ Prob	ably 4 Unknown		
ne law re has bee		Completed					24a. Was auto	nsv n	Vere autor rior to cor eath?	psy findings available mpletion of cause of		
in: Th		ပ္သ	25. Was case referred to medical			26. Place of Deat		2 No 1		2 No		
ysicle lis cert direct		0	examiner?	ER/Outpatier	nt 3 DOA Othe	NF:		dence 6 🗹 Othe	er (Specifi	Hospice		
nding Ph th.: After the function		tion:	27. Manner of Death 1	28b. Time of Injury	Work	/ at ⟨? Yes 2 □ No	28d. Describe	how injury occurre	∍d			
al or Atter after dea Director		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (a City or To	Street and Numbe wn, State)	r or Rura	I Route Number,		
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		Medical C										
To th within To th		Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed	(Month,	Day, Year)		
			If forthy lily	no	1)2	2 507		July 16	,, 20	207		
1	4		30. Name and address of person who completed cause of death (Ite	m 23a) (Type,	Print) Char	les St.	falt	6. Ms	20	20%		
	Stat jistra		31. Date filed (Month, Pay, Year) 2007 38 Registrar's Sign	lature	and I							

			State of State Amend #5 per FH 07-	Maryland - <b>19-200</b>	1 / Depa 7 <b>CNM</b> Cer	rtment of H tificate of L	ealth and D <i>eath</i>	d Mental H	ygiene Reg. No.		23945	
þ			1. Decedent's Name (First, Middle, Last)					2. Date of D	eath Day	Year	3. Time of Death	
4	Physici /Medic		CORA ELIZABETH	H GOU	RLEY			July	-	2007	11:40 P	
	Examin		4a. Facility Name (If not institution, give street and numb	per)		4b. City, Town, or	Location of D	eath	4c. Coun	ity of Death		
			Frederick Memorial Hospi	ital		Frederic				deric		
	Funeral Director		271-20-9279 1 M 2 MF	. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	Min. (Month, E	irth Da <i>y, Year)</i> 16 <b>,</b> 1923	Cou	place (State or Foreign intry) yland	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation		<del> </del>			10d. Inside City Limits	
	Maryll f sho	ō	Maryland Frederick		Evodo	ni al-					1 □Yes 2 No	
	the 128a-	Director	10e. Street and Number		Frede	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citizen o	f What Cou	intry?	
	with 3a or rt be		8302 Jordan Valley V	Wav		2170	2		Unite	d Sta	tes	
	ms 2	Funeral	11 Marital Status 12 Was Deced	ent Ever in U.S	3. 13. y	Vas Decedent of Hi	spanic Origin	(Specify Yes or N	lo- 14. R	ace - Ameri	ican Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Forc  1 □ Never Married 2 □ Married  1 □ Yes 2 □ If Yes, Give  Year or Dat	! ☑ No		f Yes, specity Cuba □ Yes 2 <b>∑</b> No	n, Mexican, Pi Specify:	uerto Rican, etc.)		lack, White cify: Wh:		
Š	72 ho natur lical E	Completed	15. Decedent's Education (Specify only highest grade completed)	Ţ	16a. Deced	ent's Usual Occupa	ation	working	16b. Kind of	Business/Ir	ndustry	
215	thin 7 e. an "r	adr.	Elementary/Secondary (0-12) College (1-4	for 5+)		kind of work done of NOT use retired	)	working				
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<u>n</u>	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Midd				
<del>Z</del> a	ould Men narke	ţ.		Weddle			Ethe		Forema			
Ma	d2sk hand 7isn traun		19a. Informant's Name/Relationship (Type. Print)  Ronica Smith / Daughter			g Address <i>(Street a</i>					·	
	1 and Healt em 2	1	20a. Method of Disposition	20b. Pla	ace of Dispos	2 Jordan	- i	Date Page	20c. Location		21702 Town, State	
Baltimore,	Eapes tment of tant: If it tury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate I	thaven	Mem.Garo	dens 07/	-	Freder	ick,	Maryland	
Ba	JAMINO CO SECURITY TO THE INTERIOR SELECTION								t, Maryl		21788	
	23a. Part1. Exist the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
4	Physician		Immediat Jause (Final disease or condition a ADRTIC STEWOSIS									
	/Medical Examiner		resulting in death)	r as a consequ								
	Examiner	_	Sequentially list conditions, b.	> VD								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. End Unorthing Cause (Disease or injury that initiated events	r as a consequ	ence or):							
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8760,	icate be executed physician and the burial-transit	dical E	d									
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P.O. Box	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcomes a light of the pregnant of the			Date of deliv	very Day Year					
ds, P.	iires that signed by d be deta	by	Part II. Other significant conditions contributing to dea	th but not resul	lting in the ur	nderlying cause give	en in Part I.				the cause of death?	
Š	w requir been si should	etec					-					
Division or Vital Records,		Completed						- au	topsy formed?	prior to co	opsy findings available ompletion of cause of	
<b>#</b>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:			Othe	or.	Death (Check only				
0		<u>۲</u>	1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No		R/Outpatien 28b. Time of	28c. Injun	4 ⊔ Nursir ⁄ at	ng Home 5 ☐ Re	sidence 6 C		ify)	
on	ding h. Afte fune	tion	1 Natural 5 Pending (Month, 2 Accident investigation	, Day Year)	Injury	Worf	k? Yes 2∐No		,,			
<u> Visi</u>	Attending Physician: r death. ector: After this certifica by the funeral director, I	Certification:	3 Suicide 6 Could not be determined 28e. Place o			eet, factory, office				mber or Rui	ral Route Number,	
á	s after s after al Dire	Sert	4 Torricide	g, etc. (Specify	,			City of 1	own, State)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the base and manner.	sis of examinati								
	To th withii To th comp	Me	29b. Signature and title of certifier			29c. License			29d. Date sign			
			> \( \( \tau_1 \)			D 4	7951		7-0	9- 3	2007	
	2		30 Name and address of person who completed cause >1BTE A. KAZMI, t	100	23a) (Type,	Print)	OSE A	tue.fre	EDERIC	lc. M	D 21701	
	Sta Registr		31. Date filed (Month, Pay Year) 2 2007 32. Re	strar's Signat	ure	bode						
				1000								

State of Maryland / Department of Health and Mental Hygiene FoAmend Item 11 mend State RegistrarWCHD/SH 7/18/2007 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year The 1ma July 15, Jane GUESSFORD 11:10a.M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 138 Buttercup Drive Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 € F 214-09-2609 87 Director 31,1919 Dec. Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Mode rthan "natural", or items 23a or 28a-f abov the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 138 Buttercup Drive U.S.A. 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No white Specify: Specify: þ -3 Widowed 4 ☐ Divorced other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)  $\widetilde{12}$ asst. manager bank 7 is marked othe treumatic avent, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic avent once: 18. Mother's Name (First, Middle, Maiden Surname) Be Earl W. Hepperle Mary Needy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Guessford - husband 138 Buttercup Drive, Hagerstown, Maryland 21740 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State July 18,2007 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME Kabut & Ola 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myocard immediate /Medical Examiner cronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physician and s the burial-transit death certificate be executed abete Box 68760, ician/Medical attending IF FEMALE: 950 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. Physi 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ cate has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? this certificate 1 Yes 2 No of Vital After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attanding 1 Natural 5 Pending Injury To the nospice within 24 hours after death.

To the Funeral Director: At 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examiner and married. mation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 MD005213 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Yu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 16 2007 Registrar

Elementary/Secondary (0-12)   College (1-4or 5+)   Director of Industrial Safety   D.C. Gov't.	15.
Charles T. Greene   July 1, 2007   2:51	Death
Holy Cross Hospital    Silver Spring	Ам
Social Security Number   Social Security Num	
ST7-18-2292   INM 2 F   87 Yrs.   Months   Days   Hours   Mrn.   Month, Day, Year)   Dec. 9, 1919   Bakerfield, Tob. State   Tob. Country   Tob. State   Tob. Country   Tob. State   Tob. Country   Tob. State   To	Foreign
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Elementary/Secondary (0-12)   College (1-4or 5+)   Director of Industrial Safety   D.C. Gov't.	
Chesapeake Crematory July 10, 2007 Beltsville, MD	
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Chesapeake Crematory July 10, 2007 Beltsville, MD	
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Physician / Medical Examiner  Physic	
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)	
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The dical Examiner  The distribution of the part of th	een eath
Due to (or as a consequence of):    Continued to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last    Continued to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last    Continued to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last    Continued to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last    Continued to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last    Continued to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last    Continued to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last    Continued to immediate cause of contributions contributions contributions of the cause of contribution in the past 12 months?   Continued to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last    Continued to immediate cause of contributions contributions contributions contributions to death but not resulting in the underlying cause given in Part I.	
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9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	
9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	
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24a. Was an autopsy findings a prior to completion of cadeath?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Probably 4 200  24b. Were autopsy findings a prior to completion of cadeath?  1   Yes   21/2 No	vailable use of
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25. Was case referred to medical examiner?  1	
25. Specify  27. Manner of Death  28a. Date of Injury  28b. Time of  28b. Time of  28c. Injury at  28d. Describe how injury occurred  (Month, Day Year)  Injury  Work?	
1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
28d. Describe how injury occurred    Manner of Death   Death	er,
The state of the s	
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Date of Injury  28. Date of Injury  28. Injury at Work?  29. Accident  3 Suicide  4 Homicide  28. Place of Death (Check only one)  28. Injury at Work?  3 Suicide  4 Homicide  28. Location (Street and Number or Rural Route Number)  28. Place of Death (Check only one)  28. Injury at Work?  3 Suicide  4 Homicide  28. Location (Street and Number or Rural Route Number)  28. Place of Injury  28. Injury at Work?  3 Suicide  4 Homicide  28. Location (Street and Number or Rural Route Number)  28. Place of Injury  3 Suicide  4 Homicide  28. Location (Street and Number or Rural Route Number)  28. Place of Injury  4 Nursing Home  5 Residence  6 Other (Specify)  28. Injury at Work?  1 Yes 2 No  28. Location (Street and Number or Rural Route Number)  28. Place of Injury  4 Homicide  28. Place of Injury  4 Homicide  28. Place of Injury  5 Pending  1 Yes 2 No  28. Location (Street and Number or Rural Route Number)  28. Location (Street and Number or Rural Route Number)  29. Signature and title of certifier  29. Signature and title of certifier  29. Signature and title of certifier  29. Date signed (Month, Day, Year)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
D00 64174 July 2, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Vikas Jogi/1500 Forest Glen Road Silver Spring, MD 20910	1
State 31. Date filed (Month, Dey, Year) 32. Tegistrar's Signature 32. Tegistrar's Signature	

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Yeld

JUL 1 0 2007

32. Registrar's Signature

AIGAI EXAIIII	an/ ner		Reg. No. Date of Death Month Day uly 14, 2007	Year	3. Time of Death 1242 hrs		
	I	4a. Facility Name (if not institution, give street and number)  146 Marine Oaks Road  4b. City, Town, or Location of Death Essex	40	: County of Deat Baltimore Co			
Funeral Director		Months Days Hours Min.	Date of Birth(MMA)	1 Forei			
nd how any		10a. State 10b. County 10c. City, Town or Location	<b>N</b>	······································	10d. Inside City Limits  1 Yes 2 No		
with the Maryland as 23a or 28a-f sho ge notified at once,	Director	Maryland Baltimore Essex  10e. Street and Number 10f. Zip Code 21221		izen of What Cou	intry?		
AID 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23s or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rical Yes 2 No	fy Yes or No-		rican Indian, Black,		
hours after natural", c	ò.	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)		Specify: Wh			
11215-0036 Idbe filed within 72 hours a dontal Hygiene. narked other than "natura event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2  17. Father's Name (First, Middle, Last) Cashier  18. Mother's Name (Fir		as Stat	tion		
21215-0036 buld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Sr	K. Ham	oton	e, Zip Code)		
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatte		Lisa A. Hampton/Aunt  20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Marzi  23. A. Hampton/Aunt  24. Place of Disposition (Name of cemetery, crematory or other place)  25. Place of Disposition (Name of cemetery, crematory or other place)  26. Place of Disposition (Name of cemetery, crematory or other place)  27. 21. Signature of Funeral Service Licensee	/07 Ba ullo Fu	ltimore	e,Maryland		
Physician /Medical Examiner		23a. Part I. Enter the disease, or commissions that caused the death. Do not enter the mode of dying, such as cardiac or restailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Alcohol and methadone intoxication  Due to (or as a consequence of):	u, ball	THIOTE,	Maryland21 Approximate Interval Between Onset and Death		
N.S. 15	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):					
be executed sician and urial - transit		d. AMENDED #23a,27,28a-f, perME,g869, 7/26/07 TT					
	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		d. Date of delive Month	rv		
ox 6876( ath certificate attending physor use as the b	sician	The state of the s					
P.O. Box 68760, so that the death certificate be e gigned by the attending physicia be detached for use as the burial	by Physician	1 Yes 2 No 9 Unknown g Unknown			Day Year		
ecords, P.O. Box 6876( te law requires that the death certificate te has been signed by the attending phys ge 2 should be detached for use as the b	þ	1 Yes 2 No 9 Unknown g Unknown	1 Yes 2  24a. Was an autopsy performed?	No 3 Pro	Day Year  o the cause of death?  obably 4  Unknown  utopsy findings available completion of cause of		
ital Records, P.O. Box 68760 ician: The law requires that the death certificate s certificate has been signed by the attending phys rector, page 2 should be detached for use as the b	Be Completed by	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25. Was case referred to medical examiner?  Hospital: 4 Inspired 2 FP/Outpetiest 3 DOA Other, Number of	1 Yes 2  24a. Was an autopsy performed?  1 Yes 2 1	No 3 Pro  24b. Were a prior to death?  1 1	Day Year  the cause of death?  bbably 4 Unknown  utopsy findings available completion of cause of  2 No		
n of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending physicians director, page 2 should be detached for use as the b	To Be Completed by	The significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25. Was case referred to medical examiner?  1 Ves 2 No  28. Date of Injury (Month, Day, Year)  28. Time of Injury 28c. Injury at Work?  28. Unknown  26. Place of Death (Check only benchmark)  26. Place of Death (Check only benchmark)  27. Manner of Death  28. Injury at Work?  28. Injury at Work?	1 Yes 2  24a. Was an autopsy performed?  1 Yes 2 1	No 3 Pro  24b. Were a prior to death?  1 🗸 Y	Day Year  the cause of death?  bbably 4 Unknown  utopsy findings available completion of cause of  2 No		
Division of Vital Records, P.O. Box 6876( all or Attending Physician: The law requires that the death certificate after death. I Director: After this certificate has been signed by the attending physele in by the funeral director, page 2 should be detached for use as the b	To Be Completed by	The significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25. Was case referred to medical examiner?  1  Yes 2 No  26. Place of Death (Check only became to the significant conditions)  1  Yes 2 No  27. Manner of Death 1  Natural 5  Pending 2  Accident Investigation 3  Suicide 6  X Could not be	1 Yes 2  24a. Was an autopsy performed? 1 Yes 2  1 Yes 2  1 Resid d. Describe how in the first continuous (Street or Town, State)	No 3 Pro  24b. Were a prior to death? 1 V V  ence 6 V Other  and Number or R	Day Year  Do the cause of death?  Dobably 4 Unknown  Sutopsy findings available completion of cause of Yes 2 No  Per: Scene		
n of Vital Records, P.O. E.  In the law requires that the d After this certificate has been signed by the funeral director, page 2 should be detached	Be Completed by	The significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25. Was case referred to medical examiner?  1  Yes 2 No  26. Place of Death (Check only became to the significant conditions)  1  Yes 2 No  27. Manner of Death 1  Natural 5  Pending 2  Accident Investigation 3  Suicide 6  X Could not be	1 Yes 2  24a. Was an autopsy performed?  1 Yes 2  1 Yes 2  1 Resid  d. Describe how in  nk  f. Location (Street or Town, State)  46 Marrine ( e to the cause(s) a	No 3 Production of the state of	Day Year  Do the cause of death?  Dobably 4  Unknown  Dobably 4  No  Unknown  Undopsy findings available completion of cause of Yes 2  No  Dobably 4  No  Do		

DHMH 17 Rev 1/2001 OCME 2006

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Re-issue

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			For State	State of Ma	aryland		artment of F		ind Me		-	1000	0-0-0-0-0-0
1	DER 14	d	Registrar  1. Decedent's Name (First, Middle, Las	et)		Cei	unicate or	Dealli		2. Date of De	Reg. No.		3. Time of Death
	Physicia		Helen	Mae		Hambu	ro			Month June 5	Day 200	Year 7	1620 <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			Hambu	4b. City, Town, o	r Location of		June J		County of Deatl	
			917 St. Clair St	:.			Hagersto				Was	hingtor	n
	Funeral		5. Social Security Number 6. S	ex 7. Age □M 2 <b>X</b> F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th y, Yea <i>r)</i>	9. Birth Con	nplace (State or Foreign untry)
ď	Director		213-24-8564 Usual Residence of Decedent		79	115.			,	Jan_5,	1928	Mary	yland
	yland now at		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	a-fsh	ctor	Maryland   Washingt	on	Hage	rstown	n						1 XYes 2 ☐ No
	ith the	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?
	s 23a		917 St. Clair St.				21742		. 0.40		U.S.		dana ladina
36	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent & Armed Forces?  1 ☐ Yes ②  If Yes, Give  Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Orig an, Mexican, Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)		4. Race - Amei Black, White Specify: Wh	
Ş	2 hou atura cal E	ed l	15. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	ation			16b. Kind	d of Business/l	ndustry
212	hin 7% e. an "na Media	Completed	(Specify only highest gra	de completed) College (1-4or 5	+)	(Give life. i	kind of work done DO NOT use retired	during most d)	of workin	g			·
2	filed wit Hygiene other the	Com	12			Sec	cretary					ga1	
D	m = 0 2	Be	17. Father's Name (First, Middle, Last)							(First, Middle,		Surname)	
<u>S</u>	12 should be filed n and Mental Hygi 'Is marked other raumatic event, t	٦	Harry J. Cave	5 D-i1		405 14-15-	- 1 (04			. Willi		T 0: -	
<u>g</u>	d2sh thand 7 Isn traun		19a. Informant's Name/Relationship (7) Cynthia Brezler /				ng Address <i>(Street</i> Lehmans						(ip Code) 21742
<u>၈</u>	Heal Heal tem 2		20a. Method of Disposition		20b. Pl		sition (Name of matory or other place			ate		ation - City or	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)		1		matory or other plac g Cremato		/7/20	107 F	Smith	sburg,	MD
a E	mit. F partm portar / injur		21. Sign that of Funeral S ce Live	·_	P		2. Name and Addre				Fund	oral Ch	anol
m	a in per		m 7/1	-		16	601 Penns	y1van:	ia Av	re., Ha	gers	town, M	D 21742
J	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.			ng, such as o	cardiac or	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Pancreatic carcinoma  Due to (or as a consequence of):										onths
AL.	Examiner		Commentation line and distance	h Hyperte	ensio	n						-7	ears
	P ≓	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a consequi	once of):							
8760,	cate be executed oblysician and the burial-transit	al E		Due to (or as a	a consequ	ierice oi).							
587	ficate phys s the	edical		.d									
Box	death certific e attending pl ed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal	death 3[	Ectopic pregnancy Other (specify)	y			23	3d. Date of deli Month	very Day Year
Ö	0 0	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown			(-,,						
Vital Records, P.	The law requires that the de te has been signed by the a rage 2 should be detached i	by	Part II. Other significant conditions of	ontributing to death bu	ut not resu	Iting in the u	nderlying cause giv	ren in Part I.		23e. Did t	_		the cause of death?
O O	aw requir s been si s should t	Completed								24a. Was		24b. Were au	topsy findings available
ř	The law cate has I page 2 s	mo								autoj perfo 1□ Yes	ormed?	prior to death? 1 ☐ Yes	completion of cause of 2 ☐ No
<u>E</u>	sician; Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				200	26. Place	of Death	(Check only o			
	Physician; this certifica	인	1 ☐ Yes 2 ☑ No	ign Play			nt 3□ DOA Oth	4 L Nur	rsing Horr	ne 5 🔀 Resi	dence 6	□Other (Spec	cify)
Division or	ending P sath. or: After I he funera	ation:	27. Manner of Death  1 XNatural 2 Accident  3 Suicide  6 Could not be			28b. Time o Injury	Wor	yat k? Yes 2 ☐ N		8d. Describe	how injury	occurred	
DIX	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubulding, etc	iry - At hoi c. (Specify	me, farm, str	eet, factory, office		2	8f. Location (S City or To		Number or Ru	ıral Route Number,
	To the Hosp within 24 hou To the Fune completely fil	edical	29a. Certifier (Check only one)  Medical Exam	ysician: To the best on the basis of and manner sta	examinat	wledge, deat ion and/or in	h occurred at the til vestigation, in my o	me, date and opinion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To t To t	Ž	29b. Signature and vitle of certifier	111	6	1 ^	29c. Licens	e number			29d. Date	signed (Month	h, Day, Year)
			MIG	J. 110	010	M	// D0022	2043			6/6/	07	
			30. Name and address of person who L. Dwight Wooster		,			D.J.	Ucce	water-	M	017/0	
×	<sup>∭</sup> Sta	te	31. Date filed (Month, Day, Year)	32 egistra	ar's Signat	ture	l Campus	Ku.,	падет	rstown,	MD	21742	
Resi-	Registr		31. Date filed (Month, Day, Year)	007	/	K A.	and a						

07-05242	
Aubrev Hewatt	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

المال	rey newall		1- For State Registrar  Certificate of Death	Reg. No.	,
Med	Physici dical Exami		1. Decedent's Name (First, Middle,Last) Aubrey E. Hewatt, <del>Sr.</del>	2. Date of Death Month Day Year July 8, 2007  3. Time of Death 1217 hrs	
Mary and			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or	Location of Death 4c. County of Death	
	F		Suburban Hospital Bethesda  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	Montgomery   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or	
	Funeral Director		525-10-6724 1X M 2 F 88 Yrs. Months Days		ıa
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	. 10d. Inside City Limi	ıts
	Maryland 28a-f show d at once.	힏	Maryland Montgomery Kensington	1 X Yes 2 N	No
0	e Mary or 28a- ied at	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?	
	with th		4408 Colchester Drive 20895  11. Marital Status 12. Was Decedent Ever In U.S. 13. Was Decedent of His	United States  panic Origin? (Specify Yes or No- 14. Race - American Indian, Black,	+
	death or iten must b	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban	, Mexican, Puerto Rican, etc.) White, etc.	
	ırs after ııral", miner	ρ	3 XWidowed 4 Divorced If Yes, Give Year 1 0 4 7 - 1 0 6 2 1 Yes 2 X No 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupat		_
	72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		
	within yiene.	dmo	4 Major, USAF	Military	
	imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Be C	17. Father's Name (First, Middle, Last) Benjamin Franklin Hewatt	18.Mother's Name (First, Middle, Maiden Surname) Lillie Beatrice Holloway	
	21, hould b nd Men is mar	P		t and Number or Rural Route Number, City or Town, State, Zip Code)	
	and 2 sho ealth and lem 27 is traumati		Holloway Hewatt/Daughter 4408 Colchest  20a. Method of Disposition 120b. Place of Disposition (Name of cer	cer Drive, Kensington, MD 20895	
	Baltimore, MD 2 pernit. Pages I and 2 shoul Department of Health and IV Important: If item 27 is m injury or other traumatic.		1 Burial 2 Cremation 3 Removal from State crematory or other place)	atory 7-23-2007 Brentwood, MD	
	altin mit. P. partme portan ury or			of Facility Simple Tribute, 1040 Rockville	
)			Ca Am Mach-Marth	Pike, Rockville, MD 20852	
	Physician /Medical	3 35	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, failure. List only one cause on each line.	such as cardiac or respiratory arrest, shock, or heart Approximate intervalence on the Approximate of the Ap	
1	xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Morphine intoxication  Due to (or as a consequence of):	2000	
		<u>ا</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
		Examiner	Cauche Enter Underlying Course (Disease or injury that initiated		
b	cuted nd ransit		events resulting in death) Last Due to (or as a consequence of):  d.  d.		
	be exection a sician a	Medical	X UNPENDED X AMENDED 1,23a,PII,27,28a-f, perME,g869.	7/31/07 TT	
	ision of Vital Records, P.O. Box 68760,  Attending Physician: The law requires that the death certificate be executed at death.  retent: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit		23b. Was decedent pregnant in the	23d. Date of delivery  Ectopic pregnancy Month Day Year	
	ox 6	Physician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		
	Division of Vital Records, P.O. Box 687 rat or Attending Physician: The law requires that the death certificars after death.  "In Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	iven in Part I. 23e. Did tobacco use contribute to the cause of death?	
	ires tha	d b	Atherosclerotic cardiovascular disease	1 Yes 2 No 3 Probably 4 V Unknown	1
	ords iw requ as been should	Completed	chronic obstructive pulmonary disease	24a. Was an autopsy findings availab prior to completion of cause of	
	Rec The Is	S		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
	/ital sician: is certil lirector	Be	examiner? [Hospital: 4   Jacobiant 2   FD/Output 2   FD/Ou	of Death (Check only one)  Other:  Nursing Home 5 Residence 6 Other:	
	of Vit ing Physic After this uneral dire	n: To	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury 28c. Injur	y at Work? 28d. Describe how injury occurred	_
	ivision or Attendiater death. Director: /	Certification:	Pending Accident Investigation Fnd 7/8/2007 Fnd 11:45 am	subject ingested drug	
		ij.	3 X Suicide 6 Could not be determined (Specify) residence	uilding, etc. 28f. Location (Street and Number or Rural Route Number, Cit Town, State) Colchester Dr. Kensington, MD	ty
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one)  29b. Certifying Physician: To the best of my knowledge, death occurred at the time, dayone)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion,	te and place, and due to the cause(s) and manner as stated.	
	_ 1	Medical	and manner stated.  29b. Signature and title of certifier  29c. License		
	(1-VA)		Wight mod O.C.M	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		}	30. Name and address of person who completed cause of death (Item 23a)	JD 04004	$\dashv$
		ate	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N  31. Date filed (Month, Days Year) 2007 32 Registrar's Signature	พบ 21201	_
	St Regist	rar	31. Date filed (Month Dayn) 2007 32 Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Kenneth H. Hall 2007 1:00 06, A M July /Medical 4c. County of Death Anne Arundel 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis Eldercare - Severna Park Severna Park 8. Date of Birth (Month, Day, Year)
Nov. 22, 1922

8. Birthplace (Sta Country)
Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 216-16-6667 Director 84 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. r than "natural", or Iteme 23a or 28e-f ehov The Medical Examiner must be notified at Severna Park MD Anne Arundel 1 ☐ Yes 2 X No Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21146 108 Hatton Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. XYes 2 □ No Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No ģ Specify: 3 Widowed 4 Divorced Year or Dates: WWII Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Lumber Company 12 i. Pages 1 and 2 should be filed witness of Health and Mental Hygier trant: If Item 27 is marked other trajury or other traumatic event, Ital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Frances Herbert Robert Lee Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
108 Hatton Drive, Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Gertrude L. Hall/ wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Glen Haven
Memorial Park July 10, 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Glen Burnie, MD permit. Page Department of Important: If any Injury or once. 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee Name and Address of acility P.A. 495 COV. RICCITE WY, - normal 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUPRANGCLEAR PROGRESSIVE Physician YUAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed ettending physicien and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be 2 No 1 🗌 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 22 No certificate 2 🗌 No 1 ☐ Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier D31136 of death (Item 23a) (Type, Print) 9005 KILBRIDE RD, BALTIMORE, MD 21236 31. Date filed (Month, Day, State JUL 1 0 2007 Registrar

		1	1 - State Registrar	,	Certificate of	Death	Re	g. No.	2005
	Physici /Medio		1. Decedent's Name (First, Middle, Last) John William	Hon-			2. Date of Death Month <b>7</b>	Day Year <b>200</b>	3. Time of Death 7:45 A M
	Examir	er	4a. Eacility Name (If not institution give street and number) Baltimore Rehubilitation Extended Care Co	in and	4b. City, Town, o	r Location of Death	ON	4c. County of Deat	'n
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age 1 M 2 □ F	(In yrs. last birtl	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 5/18/1	9. Birt	nplace (State or Foreign Untry Ohio
	iryland show	_		10c. City, Town		-			10d. Inside City Limits
	the Ma 28a-f	recto	MD Anne Arunde1  10e. Street and Number	Annapo	lis 10f. Zip Code		10	g. Citizen of What Co	1 ☐ Yes XIX No
	ath with 23a or ust be	ral Di	8 Cypress Rd.			21403		USA	•
036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Never Married 12. Was Decedent E Armed Forces? 1 □ Never Married 12. Was Decedent E Armed Forces? 1 □ Never Married 12. Was Decedent E Armed Forces? 1 □ Never Married 12. Was Decedent E Armed Forces?		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		city Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
215-0036	n 72 ho "natur edical I	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of workin	g 1	6b. Kind of Business/	ndustry
717	ed withi /giene. er than	Comp	Elementary/Secondary (0-12) College (1-4or 5+ 5+	.)	upervisor	u)		Employment	Services
and	ould be file Mental Hy arked oth atic event	Be	17. Father's Name (First, Middle, Last) Wilson Hone			18. Mother's Name Agnes W		laiden Surname)	
Maryland 21	12 sh h and 7 is m traum	្ន	19a. Informant's Name/Relationship (Type. Print)  Lynette Bushnell Hone Wife		Mailing Address (Street	and Number or Rural	Route Number,	City or Town, State, 2	(ip Code)
ore,	The Hear		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	20b. Place of cemeter	Disposition (Name of crematory or other pla	ce)	ate 2	20c. Location - City or	Town, State
Baltimore,	ent ent rt: I		4 ☐ Donation 5 ☐ Other (Specify)		Crematory	7/6/20		altimore, neral Home	
g	permit. Pepartm Departm Importar any Injui		21. Signature of Euneral Service Licensee				-	neral ноme , MD 21401	, P.A.
ř	Physician /Medical Examiner	er	Motor	consequence of consequence of the consequence of th	al Cerve	ng, such as cardiac or ZIMOMU 104 C			Approximate Interval Between Onset and Death
68/60,	death certificate be executed e attending physician and d for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a c	consequence o	f):				
C. Box	the by the ache	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of del Month	very Day Year
ds, F	w requires that the been signed by the should be detached	by	Part II. Other significant conditions contributing to death but	t not resulting in	the underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to s 2 □ No 3 □ Pr	~
Hecord	S b	Completed					24a. Was an autopsy perform 1  Yes 2	24b. Were au prior to death?	topsy findings available completion of cause of
VITal	Physician: The Is this certificate had ral director, page 2	Be	25. Was case referred to medical examiner?  1  Yes		Ott	26. Place of Death	(Check only one	9)	11
sion or	tending Physicath. tor: After this the funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation	/ 28b. T	ime of 28c. Inju	4 U Nursing Hor		nce 6XOther (Sper w injury occurred	city) Hospica
DIVISION	e Hospital or Attending P 24 hours after death. e Funeral Director: After t etely filled in by the funera	Certification:	4 Homicide Building, etc.	(Specify)	m, street, factory, office		City or Town,		
	To the Hospi within 24 hou To the Funer completely fil	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of and manner state and manner state.	examination and	death occurred at the ti l/or investigation, in my	ime, date and place, a opinion, death occurre	nd due to the ca ed at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2.	We Me	29b. Signature and title of certifier	-10	29c. Licens	se number 4 1 2 1 1	29	7 / OG	h, Day, Year)
	150	7	30. Name and address of person who completed cause of de	ath (Item 23a) (	Type, Print)	Payer F	RIval. F	Rollinga M	in 21218

Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

State

31. Date filed (Month, Day, Year)

JUL 1 0 2007

			For State	State of Mary		epartment of Certificate of		, ,	- G-D		AABE,
			Registrar  1. Decedent's Name (First, Middle, Later)	st)		Certificate of	Dealli	2. Date of Deat	eg. No		3. Time of Death
Г	Physicia /Medic		T. Doodding Hame (7 not, made, Ed	Linda D. Ja	acob			Month July	Day	Year 007	0535 A <sup>M</sup>
N.	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town	or Location of Death	1	4c. County	of Death	
46		5	Union Hospital	1 - 4 - 4		Elkto		Do But of Blat	Cec		
b	Funeral Director		5. Social Security Number 6. S 267-68-1890	ex	n yrs. last birti	rs. Months Day		8. Date of Birth (Month, Day, SEPT 3,	<sup>Year)</sup> 1943	Coun	place (State or Foreign htry) Jersey
	and w		Usual Residence of Decedent  10a. State 10b. County	10	oc. City, Town	or Location				1	0d. Inside City Limits
	daryla f sho led at	o	Maryland Cecil		E1kto						1 X Yes 2 □ No
	r 28a-	Director	10e. Street and Number		DIREC	10f. Zip Code	,	10	0g. Citizen of V	What Cour	ntry?
	th with		13 B Glen Creek	Circle		219	21		Unite	ed St	ates
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🕅 No	er in U.S.	13. Was Decedent o	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - Americ	
36	rs afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🐧 No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 N	o Specify:		Specify	Wh	ite
21215-0036	2 houral	ted	15. Decedent's E	ducation	16a.	Decedent's Usual Occ	upation	tion 1	16b. Kind of Bu		
215	thin 7: e. an "n Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work dor life. DO NOT use reti	red)	King			
7	ed wi lygien ner th	Cou	12			Bookkeepe	-T	ne (First, Middle, M	Woody		ng
Maryland	i be fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last Thomas T. Fergus				_	ine Heste		ie)	
Ž	should nd Me mark mark	2	19a. Informant's Name/Relationship (		19b.	Mailing Address (Stre				State, Zip	Code)
	s 1 and 2 of Health a ltem 27 is		Peter Jacob/Husb	and	13	B Glen Cr			, Maryl	land	21921
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at other.		20a. Method of Disposition  1 M Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.	Removal from State	Place of cemeter Fernwo Park	Disposition (Name of y, crematory or other p od Memoria	Jul 1 200	y 23,   F	<sup>20c. Location</sup> - Hopewel New Jer	1 Tow	own, State vnship,
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Lice	nsee	Tark_	Hicks Hon 103 W. St	dress of Facility Ne for Fun Cockton St	erals, P	.A. kton, M	arvla	and 21921
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do n	ot enter the mode of o	lying, such as cardia	or respiratory arre	est,	-5	Approximate Interval Between
	Physician	8 19	Immediate Cause (Final disease or condition	chen		Lines				28	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence d	<b>A</b> ):					
	- 4	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of	of):					
78	cuted id ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Pn	enesi	a			_		
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a c	•		7				
687	ficate the physical p	edical	•	d. [174]	anc	Enceloga	ing				
.O. Box (	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death	3 □Ectopic pregna 5 □ Other <i>(specify,</i>			1.	ite of delive	ery Day Year
Δ.	w requires that the d been signed by the should be detached	y Ph	Part II. Other significant conditions	contributing to death but r	not resulting in	the underlying cause	given in Part I.	23e. Did tol	bacco use conf	tribute to t	he cause of death?
ord	require sen si	ted						1 Y		3 ☐ Prol	
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	A 17 5 17 18		Other	ath (Check only on			
Ö	Phys or this eral di	1: To	1 Yes 2 Manner of Death	28a. Date of Injury	28b. T	thatient 3 DOA	4 ∐ Nursing F njury at vork?	fome 5 ☐ Reside			59)
ion	Attending r death. ector: After oy the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y n	'ear) li		vork? ☐ Yes 2 ☐ No				
Division	after des Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined			rm, street, factory, office	ce	28f. Location (Si City or Town		ber or Run	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	cal	(Check only 2 Medical Exa	hysician: To the best of r miner: On the basis of ex and manner state	xamination an	d/or investigation, in n	y opinion, death occ	urred at the time, o	date and place.	and due t	to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	-		29c. Lice	ense number	2	9d. Date signe	ed (Month,	Day, Year)
			In ceil	1de MD		De	4823		7/17	107	7
	6		29b. Signature and title of certifier  The Cell  30. Name and address of person who  The Cithin  31. Date filed (Month, Day, Year)  JUL 2 5 2	HSH MP	th (Item 23a) (	Type, Print)	mai	et elk	ton L	14	21921
	Sta Regist	ite rar	31. Date filed (Month, Day, Year) JUL 2 5 2	32 Registrar's	s Signature	Spark					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner OVERNA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5/31/1937 1 □ M 2**X**) F Days 70 Country) Indiana 262-46-7938 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other treumstic event, the Medical Examplating matter at 10d. Inside City Limits MD Prince George Mitchellville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3101 Courtside Rd. 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after in Health and Mental Hygiene. Item 27 is marked other than "natural", or Ite 1 Never Married XX Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Yetta Gordon Edward Lefkow ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 Courtside Rd. Mitchellville, MD Richard Johnson Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

XXXBurial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 7/10/2007 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD Hillcrest Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Jak 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Cause (Final Physician PARANEOPLASTIC SYNDROME disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 mon 4☐Pregnanl at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 1 ☐ Yes Completed 4 DUnknown 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? has autopsy performed certificete 2□ No Division of Vital 1 ☐ Yes 2 No 1 Yes To the Hospitel or Attending Physicien: After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA WUNG 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner Death 28b. Time of 28d. Describe how injury occurred 1 Aatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, streel, factory, office building, elc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title 29c. License number 29d. Date signed (Month, Dav. Year, ddress of person v CORMSHIGHWAY MILLERSWEET 1 0 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g830, 08/03/0/dhb Reg. No.

Reg. No. A. Krieg, Sr. Krieg, Sr. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mark Month Day Year **Physician** Mark 7:00 PM 2007 July 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 213 Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□ F Months Yrs Director <del>15</del>-82-1772 38 May 30,1969 Maryland Usual Residence of Decedent Mark Anthony Kried 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Dundalk 1 ☐ Yes 2 ☐ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ must be 927 Dalton Avenue 23a 21224 Funeral U. 14. Race - American Indian, ural", or Items 2 I Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: "natural" permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 Is marked other than Patient known as Home Improvement Roofer 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ August Carroll Krieg, Sr Josephine Mary Di'Vita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine R. Haga 927 Dalton Avenue, Baltimore Maryland 21224

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Maryland 21224 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 7/20/07 Raltimore, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses michael Margale 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final left Shoulder Physician osteosarcoma 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading control cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of Examiner sician and burial-transit that the death certificate be executed APPROVED BY MESTO Due to (or as a consequence of) Box 68760, physician Physician/Medical as the attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2□No P.0. ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1☐ Yes Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: spital: 1 Inpatient 2 | 28a. Date of Injury (Month, Day Year) 1 Yes မ 2 ☐ ER/Outpatient 3 ☐ DOA o this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death uneral Director: by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nar RES 000 July 16,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore 2401 W. Belvedere Ave Baltimore, MD 21215 Eileen Zingman, D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 2 5 2007

### 07-05454 John Christian Kline

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

PROBLEM Section 1 Section 1 Maintained 1 Sect	Offit Offitstan is	1	For State Control Cont	ר	Reg.	No.	
John Christ Can Kilne  1. Second Search Second Seco	Physici	_	. Decedent's Name (First, Middle,Last)			ay Year	3. Time of Death
## # Faith New Internation of white an extrement of the Section Name of the Section Na			John Christian Kline	*			
Supplied Directory  2 18-13-18 18 St. No. 2   P. App to type, lost bird row, and the property of the property	, .		la. Facility Name (if not institution, give street and number)  4b. City, T		th		1
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218-13-1818   XN 2   34	Funeral		). Social Security Hambor		-	Foreig	thplace (State or
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1	with the second		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceden	ent of Hispanic Origin? (	Specify Yes or No-		rican Indian, Black,
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Atherosclerotic cardiovascular disease or conditions resulting in death; Last  Sequentially list conditions, list my, leading to immediate cause, effort furnering cause or conditions resulting in death; Last  Sequentially list conditions, list my, leading to immediate cause, effort furnering cause or finary that inflated cause, effort furnering cause or finary that inflated cause, effort furnering cause or finary that inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause or feeling or finary list inflated cause, effort furnering cause of death?  The first furner furner furner furner furnering cause of death or forth			failure. List only one cause on each line.			,	
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The control of the co			or condition resulting in death)  Due to (or as a consequence or):				
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The state of the s	SOX leath e atte for u	ysic	A Was O Na C University				
State	The c	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.			
State	P.C es that gned	by			1Yes	2 No 3 P	robably 4 Unknown
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30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day Year) 7017 32 Registrar's Signature	Rec The icate	5		Of Place of Dooth (Ch.		2 10 1	165 2 160
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Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day Year) 7017 32 Registrar's Signature			( amertely				
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State 111 9 5 /1111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
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			For State	State of Ma	ryland			nt of H te of L		nd Me			00.7	
			Registrar	- 1		Cei	unca	le or L	Jeani	1 2	Date of Deat	g. No.		3. Time of Death
п	Physici	an	Decedent's Name (First, Middle, Last	•						2	Month	Day	Year	8:00 AM
	/Medic	_	ALEX	JOSEPH		KOZA					July	13,	2007	
	Examin	er	4a. Facility Name (If not institution, give						Location of				ounty of Death	
			Autumn Assis					lage:	rstow If Under 2		Date of Dish		Washir	
	Funeral		5. Social Security Number 6. S 293 – 26 – 6465	ex 7.Age MXM2□F	(In yrs. Ia	as <i>t birthday)</i> Yrs.	Months		Hours	Min	Date of Birth (Month, Day, ) FIL ,	101 c	9. BIRT	place (State or Foreign intry) choslovakia
L	Director		Usual Residence of Decedent		00	113.				71	) + + + / ,	1313	026	CHOSTOVAKIA
	and w		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Aaryl f ehc	ō	Maryland Washi	ngton		Hagei	sto	wn						1 XYes 2 No
	28a-	ect	10e. Street and Number					ip Code			10	og. Citize	en of What Cou	intry?
	With with	₫	310 Cameo Driv	Ω.				2174	Ω			- 11	I.S.A.	
	eath	era	11. Marital Status	12. Was Decedent E	ver in U.S	S. 13. 1	Was Dec			in? (Specif	y Yes or No- can, etc.)		Race - Amer	
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 Ie marked other then *neturel', or Iteme 23a or 28a-f ehow eny injury or other treumatic event, it e Mudical Examination intellibe inculted at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🗙 N						Puerto Rio	źan, etc.)		Black, White	
38	a si	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2X No	Specify:			S	Specify: W	hite
ŏ	2 ho	Completed	15. Decedent's Ed			16a. Deced	lent's Us	ual Occupa	ation	- f d.l.		16b. Kind	of Business/I	ndustry
72	hin 7	ple	(Specify only highest gra	College (1-4or 5-	r)	life.	DO NOT	use retired	during most )	or working		Sew	ing Ma	chine
5	d with	E O	12				0 w	ner				Sto	re	
פ	oth vent	Be	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (	First, Middle, A	Maiden S	'umame)	
<u>a</u>	Aente Aente rked	ToE	Samuel	ŀ	<oza< td=""><td>k</td><td></td><td></td><td>E</td><td>sthe</td><td>r</td><td></td><td>Grue</td><td>n</td></oza<>	k			E	sthe	r		Grue	n
Maryland 21215-0036	and ham		19a, Informant's Name/Relationship (				_						Town, State, Z	
	and salth		Susan Roza	Daughte	-				Circle					d 21742
ore	of He of He roth		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐	Demoval from State	20b. PI	lace of Dispo emetery, crer	sition (N natory or	ame of other plac		Dat		20c. Loca	ation - City or	Town, State
Ĕ	Peg nent ant: b		4 Donation 5 Other (Specif		Ве	t Olam	ı Cen	etery	/ C	7–16-	-07	Beac	:hwood,	Ohio Ohio
Baltimore,	permit. Departrimportu		21. Signature of Funeral Service Licer	1500		22	Name Ar	nd Addres	K Facility	ffmar	n Funer	al H	lome, I	nc.
m	89 = 9		R. hoel-	Brady	-	4	lO Ea	st Ar	ntieta	m Str	reet. H	ager	stown,	Md. 21740
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death	. Do not ent	er the m	de of dyin	g, such as c	cardiac or r	espiratory arre	est,		Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	a Deme	1.									Onset and Death
	/Medical		resulting in death)		consequ	ience of):			4		g)			
	Examiner		Conventingly list conditions	Hube	rta	nsine	2 (	avo	liovo	2 SCu	lax	Di.	sease	157
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to be as a	consequ	ience of):								/
	ocute nd trans	Examiner	that initiated events	c										
Ö,	e exe ien a urial-	Ë	resulting in death) Last	Due to (or as a	consequ	ience of):								
8760,	icate be executed physicien and s the burial-transit	dical	•	d										
ဖ		Med	IF FEMALE:											
Вох	eath certifii attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetal	death 3		pregnancy				23	3d. Date of deli Month	very Day Year
П	e dea	sici	1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown	time of de	eath 5	Other (	specify)						
<u>Ч</u>	thet the death cer ed by the attendir detached for use	by Physiclan/Me	9 Unknown	and the state of a state to	1 0 0 1 0 0 0	iting in the c	o doch in a		on in Dard I		23e Did tot	2000 1161	e contribute to	the cause of death?
Ś	Physician: The law requires thet the death certificate this certificete has been signed by the attending praid director, page 2 should be detached for use as		Part II. Other significant conditions of	onthouting to death bu	111011850	aung in tile u	паепунц	Cause give	en ur ranti.			s 2 🗆		
ord	een s	Completed											1110	
Ö	law las b	ple									24a. Was a autops	V	prior to d	topsy findings available completion of cause of
<u> </u>	The ete h	S C									perform 1 ☐ Yes 2	No No	death?	2 No
ita	cian: ertific	Be	25. Was case referred to medical examiner?					14.		of Death (	Check only on	θ)		. ASSISTED
×	hysic his c	ပ	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatier		ER/Outpatier			4 🗆 Nui		5 Reside		Other (Spec	property) PEIVING
n	ng P fter t inera	ü	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury		28c. Injun Worl			d. Describe ho	w injury	occurred	•
sio	eath.	catl	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2□N				41	-10 11
Division of Vital Records, P.O.	or Attending siter death. Director: After in by the fune	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At ho . (Specify	ime, farm, str /}	eet, fact	ory, office		28	City or Town		Number or Hu	ral Route Number,
	Hospital 24 hours e Funerel C		29a. Certifier Certifying Pt	ysician: To the best of	f les s	uladaa daat		d at the time	a data and	d alasa an	d due to the e	31100/01 0	and manner as	stated
	Hos 24 ho Fun staly (	edical		niner: On the basis of and manner sta	examinat									
	To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funerel Director: Affer this certificete has completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifier	310			2	9c. License	e number		2	9d. Date	signed (Monti	h, Day, Year)
}	⊢ s ⊢ ō		-				4	0.7	232	7		67_	13-7	2007
			30. Name and address of person who	completed cause of de	ath (Item	23a) (Type.	Print)					ľ	-	
91	4-6			aseem M.[				1 Co	urt,	Hage	erstow	'n,	Md. 2	1740
	Sta		31. Date filed (Month, Day, Year)	32. Registra		ture	-							
	Registr	ar	JUL 1 a 2	11111		4	<b>7</b>							

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #5 per FH 07-19-2007 CN Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day $A^{\ M}$ 2007 John Ju1y Α. Lengye1 8 8:50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2771 Lynn Street Frederick Frederick 8. Date of Birth (Month, Day, Year) Dec. 25, 19 <sup>5. S</sup>1063Se332VN37752 163-32-6132 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 65 1941 Pennsylvania Dec. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Frederick Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 21704 2771 Lynn Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 📆 Married 2 XNo White 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)

Printing Analyst

Resthaven Mem. Garden 7/13/2007

20b. Place of Disposition (Name of cemetery, crematory or other place)

PAPILLARY THANSITIONAL CELL CANGE

3 DEctopic pregnancy

28c. Injury at Work?

🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

5 Other (specify)

Part Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

4□Pregnant at time of death

Government

20c. Location - City or Town, State

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 2007

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Frederick, Maryland

Approximate Interval Between Onset and Death

YEAR-3

Year

18. Mother's Name (First, Middle, Malden Surname)

1621 Opossumtown Pike, Frederick, MD 21702

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed

1 Yes 2 No

28d. Describe how injury occurred

Helen Matta

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22. Name and Address of Facility Stauffer Funeral Home

2771 Lynn Street, Frederick, MD 21704

Physician /Medical Examiner

Department of H Important: If ite any injury or ot once.

**Physician** 

/Medical

10a State

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Immediate Cause (Final

So pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 Yes 2√2 No

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only onel

disease or condition resulting in death)

IF FEMALE:

John A. Lengyel 19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

Peg Lengyel / Wife

1 Burial 2 □ Cremation 3 □ Removal from State

Examiner

**Funeral** 

Director

r 28a-f show notified at

ms 23a or 7

item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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death with the Maryland

Physician/Medical Examiner and the burial-tran attending physician use as for been signed by the should be detached Completed by certificate has be irector, page 2 s director, Be Certification: To this funeral After the f filled in by

edical

pletely

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician; s after death. 24 hours a Hospital he in 2

To t With To t	Σ	29b. Signature and title of certifier  Hearth Comm	72 mp	29c. Lice	31761		2
10		30. Name and address of person who complete			FREDERICK	ML	)
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 1 2 2007	32. Degistrar's Signatur	a species	,		
DHMH 17 Rev 1/2	2001			ORIGINAL			

5 ☐ Pending investigation

6 Could not be determined

		1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment o			i Mental Hy	giene	10.7	2595
Dhysisi	-	1. Decedent's Name (First, Middle, Las	•					2. Date of D	aath	Yeer	3. Time of Death
Physicia /Medic		Ralph Edward Lus		•				July	13	2007	7:45 P
Examin	er	4a. Fecility Name (If not institution, give	street and number)		4b. City, To			ath		nty of Death	
		NMS Healthcare		//	Hager					shing	
Funeral Director		217 30 0310	X / Age XIM 2□F	73 Yrs.			Jnder 24 H ours M		1933	9. Birth	place (State or Foreigntry)  MD
Maryland -f ehow	tor	Usuel Residence of Decedent  10a. State 10b. County  MD Washin	gton	10c. City, Town or L Hagers							10d. Inside City Limit
h with the 3a or 28a at be noti	Funeral Director	10e. Street and Number 631 Guilford Ave	nue		10f. Zip Co	ode 1740			10g. Citizen d	of What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 le marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event. The Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Droorced	12. Was Decedent E Armed Forces? 1 Armed Forces? 1 Armed Forces? New Year or Dates:		Was Decedent If Yes, specify 1 ☐ Yes 25		nic Origin? exican, Pu	(Specify Yes or Nearto Rican, etc.)	o- 14. R B	ace - Americal Ack, White, cify:	
permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental hygiene. Important: If item 27 le marked other than "natural", or any injury or other traumatic event, the Medical Examples.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation fe completed) College (1-4or 5-	(Give	dent's Usual C kind of work of DO NOT use i	Occupation done during retired)	g most of w	rorking	16b. Kind of	Business/In	·
should be filed and Mental Hygis marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Ralph Edward Lus	<u> </u>				Mild	ame (First, Middle red Louis	se Bake	r	
1 and 2 sho Health and Hem 27 le m		19a. Informant's Name/Relationship (T Gloria J. Harden	/Pe, Print) / Sister	19b. Maili 631	ng Address (S Guilfo	treet and A	venue	Aural Route Numb , Hagers	er, City or Tow LOWn , M	m, State, Zip D 2174	(Code) +0
Pages 1 and of He int: If item		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,		20b. Place of Dispondence Commetery, creed Smithsbu	matory or othe	r place)	v   07/	Date 16/2007	20c. Location		
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		2	2. Name and A	Address of	Facility G		Minnic	h Fune	eral Home
Pnysician		23a. Pert 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused to ne cause on each line	the death. Do not en	ter the mode o	f dying, su		ac or respiratory a		,	Approximate Interval Between Onset and Death
ate be	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):  consequence of):	ictine	Pu	lme	mayy P	islas	•	2/2
w requires that the death certific been signed by the attending p should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregr Other (specif					Date of delive	ery Day Year
quires that in signed b uld be deta	ρ	Part II. Other significant conditions co.	ntributing to death but	not resulting in the u	nderlying caus	e given in l	Part I.		obacco use co Yes 2□No		ne cause of death? ably 4 ∐Unknowr
	Completed		· · · · · · · · · · · · · · · · · · ·					24a. Was auto perfo 1  Yes	an 24b osy ormed? 200 No	death?	psy findings available appletion of cause of 2 No
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						eath (Check only o	one)		
hys this	tion; To	27. Manner of Death  1 Natural 5 Pending	lospital: 1 Inpatien 28a. Date of Injury (Month, Day	28b. Time of	28c.	Other: 4! Injury at Work? 1  Yes	_	Home 5 Resi			()
or At after of Direction by	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)		=		28f. Location ( City or Tou		nber or Rura	l Route Number,
Hospi 4 hou Funer ely fill	edical C	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sicien: To the best of ner: On the basis of e and manner state	examination and/or in	occurred at the vestigation, in a	ne time, da my opinion	te and place, death occ	ce, and due to the curred at the time,	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)
To the To the Complet		29b. Signature and title of certifier			29c. Lie	cense num	ber		29d. Date sign	ed (Month,	Dey, Year)
8,1		100				52	323		67-1	6-2	007
411		30. Name and address of person who co Farid Murshed, 1				n, MD	2174	0			
Stat Registra	·C	31. Date filed (Month, Day, Year)  JUL 16 20	32 Parjistrar	's Signature	anth			-			

		4	For State Registrar	te of Maryland / Depa Cei	artment of Heal rtificate of Dea			iene eg. No.	93061
	Physicia	_	1. Decedent's Name (First, Middle, Last)  MARIE MANGASARIA	N			Date of Deat July 6,		3. Time of Death 4:15 AM
i ja	/Medic Examin	al	4a. Facility Name (If not institution, give street a		4b. City, Town, or Loca		July 0,	4c. County of Deat	
N.	31 41 42	ii.	Suburban Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Bethesda	Jnder 24 Hrs.	3. Date of Birth	Montgome 9. Bird	hplace (State or Foreign
	Funeral Director		214-82-6870 1 M 2		Months Days Ho	ours Min.	(Month, Day, Sept. 2	7,1925 Ir	ountry)
	Aaryland f show ed at	or	Usual Residence of Decedent	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	3a or 28a- st be notifi	al Director	10e. Street and Number 714 Quince Orchard B	lvd. #102	10f. Zip Code 2087	'8		Og. Citizen of What Co United Sta	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married	TYes 2 N No	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🌠 No Sp	nic Origin? (Spec lexican, Puerto F pecify:	oify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	e, etc.
Maryland 21215-0036	ithin 72 hou ne. han "natura e Medical E	Completed		oleted) (Give life.	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of workin		16b. Kind of Business.  Own Home	/Industry
and 21	il Hygi other ent, t	Be	12 17. Father's Name ( <i>First, Middle, Last</i> ) Anthoin Bernardi	Home		Mother's Name Sophie		Maiden Surname)	
	nd 2 should bilth and Ment 27 Is marked r traumatic e	ဥ	19a Informant's Name/Relationship (Type. Pr Viguen Mangasarian		ing Address (Street and Korman Cou			r, City or Town, State,	Zip Code)
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev once.		20a. Method of Disposition  1 ☒ Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	al from State	osition (Name of ematory or other place) Mem. Park	July 200	10,	20c. Location - City or Rockville,	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	Q15 1	2. Name and Address of O East Deer	Park D	r. Gait	hersburg,	
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition a	is the cause the death. Do not en use on each line.  Metatatatic  Due to (or as a consequence of):	ter the mode of dying, si		r respiratory arr	rest,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):					
.O. Box 68	ath certifi ittending or use as	Physician/Medi	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	l Blivery Day Year
<u>α</u>	uires that the de n signed by the a Id be detached f	Ď	Part II. Other significant conditions contribu	ing to death but not resulting in the	underlying cause given in	n Part I.	23e. Did to	obacco use contribute ′es 2 □ No 3 □ F	
Division or Vital Records,	law asb	Completed						an 24b. Were a prior to death? 2 No 1 □ Ye	
Vital	Physician: The this certificate fral director, page	Be	25. Was case referred to medical examiner?	al:	Other	6. Place of Death			/6.0
on or	ding Phys	ion: To	1 Yes 2 No	a. Date of Injury (Month, Day Year)  1	of 28c. Injury at Work?		-	dence 6 Other (Sp now injury occurred	еспу)
Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:		e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number or I vn, State)	Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	Medical C	(Check only 2 Medical Examiner:	<ol> <li>To the best of my knowledge, dea On the basis of examination and/or and manner stated.</li> </ol>	ath occurred at the time, investigation, in my opin	date and place, ion, death occurr	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To th Withir To th COMP	Me	29b. Signature and title of certifier	1	29c. License no	umber 3883		29d. Date signed (Mo.	
•	5		30. Name and address of person who complete	ted cause of death (Item 23a) (Type	Print\		-		06,2007
			31. Date filed (Month, Day, Year)  JUL 1 1 2007	7707 Medical Cen	ter Dr #30	o Rock	willer.	MD 2085	0
	St Regist	ate rar	JUL 1 1 2007	Bour IF A	action				

		1	For State Registrar	State of N	Maryland		artment of F				iene	117	233	
	2 3 3 3		Decedent's Name (First, Middle, Last)		_					2. Date of Deat	h	Vana	3. Time of	Death
	Physicia		Amelia Metheney							July 08	, Day 2	007	6:20	P M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number	or)		4b. City, Town, o	or Location	of Death			ty of Death		
			Heartlands Assisted				Severna					Arun		
Ny	Funeral		5. Social Security Number 6. Sex	7.7 M 2₹ <b>X</b> F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day	Year)		place (State ontry)	or Foreign
	Director	-	215-09-8104 Usual Residence of Decedent		95	113.				Dec. 23	, 1911	⊥ Mary	yland	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation					1	10d. Inside C	•
	Many 1-1 sh	ţŏ	MD Anne Arun	del	Sev	erna F	ark			_			1 🗆 Yes	2 <b>∑</b> No
	or 28,	lrec	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Coul	ntry?	
	23a c	Funeral Director	297 North Drive				21146				USA		1	
	teme	nue	11. Marital Status	2. Was Decede Armed Force	s?	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Ori an, Mexicar	rigin? (Spec n, Puerto R	offy Yes or No- Rican, etc.)		ace - Americack, White,		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date:	_		1 □ Yes 2 <b>X</b> No	Specify:	•		Spec	ity: Wh	nite	
21215-0036	within 72 hours after death with the Maryland ans. tten "natural", or iteme 23a or 28a-1 show he Madical Examiner inst be notified a	ed	15. Decedent's Educ	ation		16a. Dece	dent's Usual Occu	pation	- 4 4 · · · · · · · · · · · · · · ·	_	16b. Kind of	Business/Ir	ndustry	
75	hin 72 n "nu Medi	piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-40	or 5+)	life.	kind of work done DO NOT use retire	ading mos	st of workin	9				
2	e filed within al Hygiene. I other then vent, the Me	Completed	12			Home	emaker				Home			
p	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Suma	ıme)		
yla	should nd Men marke	ဥ	Alfred Poffen	D.:-		105 11-11	ng Address (Stree	1		theiss	City or Tow	m State 7i	n Code)	
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ariment of health and Mental Hygiene. ortant: if item 27 is marked other then "natural; or tieme 23a or 28a-f show injury or other traumatic event, the Madical Examinar must be notified at injury or other traumatic event, the Madical Examinar must be notified at e.g		19a. Informant's Name/Relationship (Typ. Linda J. Seivert/		r		North Dr						<i>p</i> 0000)	
	1 and Healt em 2	i	20a. Method of Disposition	Dadgiree	20b. P	lace of Dispo	sition (Name of	Ţ	Da	ate	20c. Location		own, State	
100	Pages nent of int: if it ury or o		1X Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	ite Mea	dowric	natory or other pla dge Memor	ial	July 2007	12,	Elkrid	ige, N	⁄ID	
Baltimore,	permit. Page Department of important: if eny injury or once.		21. Sign turn of Furth A Service License	4//		Ba	2. Name and Addr Arranco 8 95 Gov. F	ess of Facili	P.A	. Seve	erna Pa erna Pa	irk Fu	neral	Home 16
	40		23a. Party. Enter the disease, or complic	cations that cau	sed the death							1111	Approxima Interval Be	te
8	Physician		shock, or heart failure. List only on Immediate Cause (Final	$\bigcirc$	mino.	36 st	ruchik	Pu	Om	3000	Dic	Paca	Onset and	
	/Medical		disease or condition resulting in death)		as a consequ	uence of):	aciro	_ / 4	UCA 17C	Mar of	0.0	C .676	8	-6.3
	Examiner		Sequentially list conditions											
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):								
	be executed sicien and burial-transit	Examine	that initiated events cresulting in death) Last	Due to (or	as a conseq	uence of):								
760,	be ex icien burial	calE		000 10 (0.	40 4 4 4 1 1 1 4 1	201100 0171								
687	5 % 6													
×	The law requires that the death certificat tee has been signed by the attending phy tage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outco			<b>78</b> . 63				23d. [	Date of deliv		
Box	death a atte d for	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnan	n 2∏Feta tat time of d		□Ectopic pregnan □ Other (specify)	cy			1	Month	Day	Year
0	by the datached	hys	9 Unknown	9 Unknow	n 									
S, P	es that igned l	ру Р	Part II. Other significant conditions con	- /	1	ulting in the u	inderlying cause g	iven in Part	1.		bacco use co		the cause of obably 4	
ord	w require been si should l	ted	Congestive	- W	art	70	ume			101	′es 2□No		Doably 4	JOHAHOWH
Records,	law r as be	Completed	dementia							24a. Was autop		o. Were aut prior to c	topsy findings completion of	available cause of
<u>ح</u>	(0)	Son									2 No	1 Yes	2 No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred edical examiner?	lospital:				thon		(Check only o	800	/	Asir	ted
of	S S	. To	1 Yes 2 No	1 🗀 Inp		28b. Time	30 DOX	4 🗆 14		ne 5 Resid			eny) Z/	ing
	ding Pt h. After th funeral	ton	1 Patural 5 Pending 2 Accident Investigation	28a. Date of (Month,	Day Year)	Injury		ork? ⊒Yes 2[	□No					0
Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, farm, s	treet, factory, office	9	2	28f. Location (S City or Tox		mber or Ru	ral Route Nu	mber,
ă	after of in Direction of in E	Certification:	4 Homicide	building	, etc. (Specif	<i>'y)</i>				City of 104	ni, State)			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	sician: To the bas ner: On the bas and manne	is of examina	owledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date a opinion, de	and place, a eath occurre	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause	(s)
	To the within To the comple	Me	29b. Signature and title of certifier				1 '	nse number			29d. Date sig	ned (Month	h, Day, Year)	~
	, 60	P		1 1	1	M	D D	507	25		1-	7 - !	200	/
	() (B)		80. Name and address of person who co	mpleted cause	of death (Iter	n 23a) (Type	, Print) 1/	,	1/11		11-	MA	211	08
	-12		JenniterKieding	ger &	ool V	eter	Print)	vy/	VIII	ersvil	le!	110	11/2	08
	Sta Regist		31. Date filed (Month, Day, Year)  JUL 1 0 20	07 32.	gistrar's Signa	JE A	back	U						

			1 - State Amend Items 23a	te of Maryland ,Pt I,II,2	d / Depa 5,27,27	irtment of H	lealth and ME <sub>4</sub> C870	Mental Hyd , <b>08/03/0</b>	giene <b>7dhb</b> Reg. No.		23363
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Voar	3. Time of Death
	/Medic	al	John James Mahoney, J			th City Town a	. I i i Di	July	6, 2	007	2:05 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street a Anne Arundel Medical			4b. City, Town, or Annapo		n	,	Arund	el
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt		9. Birthplac	ce (State or Foreign
L	Director		263-24-9724 <sup>1</sup> XX <sup>2</sup>	□F   87	Yrs.	Months Days	Hours Min.	June 11	, T920	New Y	ork
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10d	. Inside City Limits
	Mary Ff she fied a	tor	Maryland Anne Arunde	1	An	napolis					1√√Yes 2 No
	th the or 28¢ e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country	?
	ath w		20 Severn Avenue			2140			United		
	ter de items	Funeral	11. Marital Status 12. Warried 1 Never Married 2 Married 12. Warried	as Decedent Ever in U. med Forces? Yes 2 \( \text{No} \) \( 19 \)	S. 41- 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black	- American c, White, etc	
920	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by	If \	res, Give ar or Dates: 19	1 1	☐ Yes XX No	Specify:		Specify:	Whit	e
2-0	72 ho natur dical l	eted	15. Decedent's Education (Specify only highest grade comp	pleted)	(Give	ent's Usual Occup	during most of wo	rkina	16b. Kind of Bu	siness/Indus	stry
21215-0036	within ene. than " he Mec	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+)	life. E	00 NOT use retired Steam fit	1)		Indu	stria	1
<b>d</b> 2	filed Hygi ther		17. Father's Name (First, Middle, Last)					me (First, Middle,			
lan	should be nd Mental marked o	To Be	John J. Mahoney, Sr.				Lillian	Schutte			
Maryland	2 shol and N is ma auma		19a. Informant's Name/Relationship (Type. Pri	,	1	g Address (Street					ode)
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Robert K. Mahoney / S			evern Ave	Anna	polis, Ma	aryLand 20c. Location - 0		State
Baltimore,	g <b>= 5</b>		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	al from State	emetery, cren	natory or other plac	i i			-	
Ħ	구두말금		4 □ Donation 15 □ Other (Specify)  21. Signature of Funeral Service Licensee	Baı	timore 22	Cremator  Name and Addres	ss of Facility $J_0$	0/2007 I	Baltimor aylor Fu	e, Ma neral	ryland Nome, Ind
ä	permi Depar Impor any ir		Michael of Strom		1	47 Duke o	of Glouce	ester St	. Annapo	lis,	MD 21401
H			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death se on each line.	n. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory ar	rrest,	l Ir	pproximate nterval Between Onset and Death
I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Such	nel	Hemat	ome	Α.	ATI	111	de
	Examiner			Due to ( ) s a consequ	uence of):	-	20	1. 12.	. 11 11		10
9		ner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	Cue to (or as a consequ	uentes or):		LOID	1140	XAMMER		accor
	ecutec and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Hyper	leur	<u> </u>	/ <b>/ /                                </b>	WEDICAL E			yen
38760,	icate be executed physician and s the burial-transit			Due to (or as A consequ	uence or):	X	FIC FRON APPRI	"U			<b>4</b>
687		edical	d				Blass				
Вох	death certifics e attending ph d for use as t	an/M	230. was decedent pregnant	res, outcome pf pregna □Live birth 2□Fetal		Ectopic pregnancy	,		I	e of delivery	
В	ie dea the att	Physician/M	1 Nes 2 No 4	□Pregnant at time of de □Unknown		Other (specify)			Mor	nth D	ay Year
α.	uires that the de signed by the a Id be detached f		Part II. Other significant conditions contribution	ng to death but not resu	ulting in the ur	derlying cause give	en in Part I.	23e. Did to	obacco use contr	ibute to the	cause of death?
Records,	requires een sign nould be	d by	Pneumonia, Hypertensi	on				1 🗆 🗅	Yes 2□ No	3 ☐ Probab	oly 4 Unknown
000	S 0 0	Completed						24a. Was	an 24b. V	Vere autops	y findings available
- E	The ate h	mo							rmed?	eath?	letion of cause of
Vital	Physician; Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	/		Loub		ath (Check only o	ne)		
o	Phys this rat dir	. To	X les Ze No	" 1 Hinpatient 2 □ I . Date of Injury	ER/Outpatien 28b. Time of		4 ☐ Nursing F	dome 5 ☐ Resid	dence 6 Other		
ion	Attending r death. ector: After by the fune	ation	Templural 5 Pending	(Month, Day Year)     <b>known</b>	Injury <b>Unknow</b> i	28c. Injun Worl	k? Yes 2 <b>⊈</b> No	Multiple			
Division	r Atte er dez irecto	Certification:	4 Homicide	Place of injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (S City or Tov	Street and Number	er or Rural F	Route Number,
	ospital o hours aft uneral Di ly filled ir			known				Unknow	1		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: (Check only one) Medical Examiner: O								
	To the within To the Compl	Me	29b. Signature and title of certifies			29c. License			29d. Date signed	(Month, Da	ay, Year)
	-x/	)	Hung of la	5		125	3111		+/6	10	
V	JAC),C	-	30. Name and address of pelson who complete	·		,				1	
	Sta	te	31. Date filed (Month, Day, Year)	2001 Medica 32. Registrar's Signat	al Par	kway Anr	apolis,	MD 2140	1		
	Registr		JUL 1 0 2007	32. Registrar's Signat	J. A.	book					

07-05225

# Please Type or Print in Black Indelible Ink. Exagre All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

illiam Alian Ot	1	State of Maryland / Departme	te of Death	Reg.	No.	
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death		Time of Death
ledical Exami	ner	WILLIAM ALLEN OUTTEN		July 8, 2007		<b>0</b> 345 hrs
		4a. Facility Name (if not institution, give street and number) 2053 Bypass Rd.	4b. City, Town, or Location of Death Pocomoke City, MD		4c. County of Death Worcester	
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		. 8. Date of Birth	(MM/DD/YYYY) 9. Birthp	lace (State or
Director		212-76-2445 1XM 2F 47	Yrs. Months Days Hours Min	10/18/1	Foreign Count	<sup>ny)</sup> Maryland
, tuny		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town of the county	r Location		10	d. Inside City Limits
Aaryland 28a-f show any 1 at once	_	MD Worcester Stockto	on		1	Yes 2 X No
larylar 28a-f at on	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country	P
th the Maryland 23a or 28a-f sho notified at once		5477 Stockton Road	21864		USA	
h with ems 2.	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - America White, etc.	n Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mornal Hygier than teath and Mornal Hygier than "natural", or items 23a or 28a-fish traumatic event, the Medical Examiner must be notified at once		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: Whi	.te
urs aft tural"	dby	15. Decedent's Education (Specify only highest grade completed) 16a. D	Decedent's Usual Occupation (Give kind of		16b. Kind of Business/Ind	ustry
5 72 ho nn "na sal Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use ret	rea)		
OO3( within iene. er tha	ᇍ		ruck Driver	e (First, Middle, Ma	Transportat	ion
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last)  Vaughn Nelson Outten		Paradise		
212 uld be Menti mark c even	9 9	19a. Informant's Name/Relationship (Type, Print )	. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, State, Z	ip Code)
MD id 2 sho lith and m 27 is aumati	3		.O. Box 271, Pocomo			
re,   s l and f Heal If item er tra			f Disposition (Name of cemetery, ory or other place)		20c. Location - City or To	
Page Page nent o		4 Donation 5 Other Specify: Salisk		1/2007	Salisbury,	MD 21804
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hour Department of Fleath and Menal Hygiene. Important: If item 27 is marked other than "nate injury or other traumatic event, the Medical Examinjury or other traumatic event, the Medical Examingury or other traumatic event, the Medical Examingury or other traumatic event, the Medical Examingury or other traumatic event, the Medical Examingury or other traumatic event, the Medical Examingury events.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility HOLLOWAY Funeral Ho	ome. PPg	comoke City	MD 21851
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do no	t enter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval
Medical	8 11	failure. List only one cause on each line.  Immediate Cause (Final disease a Contact Gunshot Wound of F	Head			Between Onset and Death
caminer		or condition resulting in death)  Due to (or as a consequence of):				
	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examin	Cause. Enter Uncerthing Couce (Disease or injury that initiated C.				
ted 1 Insit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.				
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	Medical	UNPENDED AMENDED				
760, cate be physic the bur	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delivery	v Voor
certification of the second of	cian	past 12 months?  1 Live birth 2 4 Pregnant at time of death		апсу	Month Da	y Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown				
P.O. Bes that the digned by the	by P	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		oacco use contribute to the	
S, F quires an sign	ted 1			24a. Was a		ppsy findings available
cords law requi has been	Completed			autops perforr	med? death?	mpletion of cause of
of Vital Rec ling Physician: The l After this certificate funeral director, page	Sol		26.Place of Death (Check	1 Yes 2	No 1 ✓ Yes	2 No
ital sician: si certi irector	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/O	vOth ac.		Residence 6 🗸 Other:	Scene
of Viring Physical After this uneral dir	2 2	1 ✓ Yes 2 No Impation 2 = 27. Manner of Death 28a. Date of Injury 28b. (Month Day Year) 28b.	Time of Injury 28c. Injury at Work?	28d. Describe h Subject shot	ow injury occurred	
ion tendin eath. tor: A	atio	1 Natural 5 Pending 2 Accident Investigation Page 1203. Pending Jul 8, 2007 0348				
Division of Vital Records, tat or Attending Physician: The law requin is after death.  Director: After this certificate has been is aled in by the funeral director, page 2 should be after than the threat of the this page 2.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office building, etc.	or Town, St	treet and Number or Rura tate) Road, Pocomoke City,	
DIVI ospital or a hours after meral Dir		29a, Certifier	ath accurred at the time, date and place, an			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only 1 Certifying Physician: 16 the best of my knowledge, dec one) 2 ✓ Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date a	and place, and due to the	cause(s)
T. W. T. O. O. O. O. O. O. O. O. O. O. O. O. O.	Me	29b. Signature and title of certifies	29c. License number		29d. Date signed (Moni	th, Day, Year)
		( a Inbelle	O.C.M.E.		July 8, 2007	
		30 Name and address of person who completed cause of death (Item 23a)	1 Penn Street, Baltimore, MD 21	201		
ET 6			renn Sueet, ballimore, MD 21			
Regis	tate strar	1007	Sparle			
DHMH 17 Rev 1/	2001	OCME OR	RIGINAL			

			1 _ State	State of	Maryland	-	artment of I		nd Mer		giene Reg. No.:	4 5	33961
			Registrar  1. Decedent's Name (First, Middle, Last)							Date of Dea		•	3. Time of Death
	Physicia /Medic		Pierce A.	Owens						Month Tu/y	03 03	2007	0640 AM
	Examin		4a. Facility Name (If not institution, give s Doctors Community				4b. City, Town, Lanham		Death			County of Death	orges
	Funeral Director		5. Social Security Number 6. Sex 1851	M 2□F	Age (In yrs. la 79	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		Min. 8.	Date of Birt (Month, Day 3/06/	h y, Year) 1928	9. Birthp Coun New	lace (State or Foreign try) York
	yland now at		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	he Mar 8a-f sh otified	Director	Maryland Montgomer	У	Tal	koma P	ark_ 10f. Zip Code				10a Citiza	en of What Coun	1 XYes 2 No
1	h with t 23a or 2 Ist be n	al Dir	10e. Street and Number 907 Wabash Avenue				20912					S.A.	uy:
17CC	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertall Hydiene. Important: I firem Z1 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I	11. Marital Status  1 Never Married 2 Married 3 Widowed WXDivorced	2. Was Deced Armed Forc 1½ Yes 2 If Yes, Give Year or Date	es? !∏ No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No		n? (Specify Puerto Ric	/ Yes or No an, etc.)		4. Race - Americ Black, White, Specify: Wh:	
D/er	n 72 ho "natur edical l	Completed	15. Decedent's Educ (Specify only highest grade	completed)		16a. Deced (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most o	of working	- 1	16b. Kin	d of Business/Ind	dustry
212	ed withi /giene. er than t, the M	Comp	Elementary/Secondary (0-12)	College (1-4			untant					Firm	
eNS aryland	id be file ental Hy ked oth ic even	To Be	17. Father's Name (First, Middle, Last) Pierce Thomas Ower	ns				Clara	,	irst, Middle, 1e	Maiden S	Surname)	
Pary	2 shoul and M Is marl aumati	F	19a. Informant's Name/Relationship (Typ	e. Print)			ng Address (Stree						Code)
3 <b>ĕ</b>	s 1 and F Health tem 27 other tr	3	Mary Beatrice Barlo 20a. Method of Disposition	ow/ Fri	20b. Pl	ace of Dispo	Kenhill esition (Name of matory or other pl	- 1	, Bow Date			1715 ation - City or To	wn, State
() () Baltimore	Pages ment of ant: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		ate	ar Hil	1 Cemete	ry 0	7/11/			land, M	aryland
Balt	permit. Depart Import any Inj once.	2 Y	21. Signature of Funeral Service License	1			2. Name and Add				-	is Road NS FUNE	RAL HOME
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	ations that cau e cause on eac	used the death								Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acu	te M		ardia	l In	farc	+			hour
	Examiner		Sequentially list conditions.	Cov	ona	09	artery	d:	sea	se			10 years
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consequ	ien⊘ <b>s</b> /of):							
8760,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (o	r as a consequ	ence of):							
	rtificate ng physi as the b	ledica	d										
J. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affect cleath.  To the Funeral Director: Affect his certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal nt at time of de	death 3	□Ectopic pregnan □ Other <i>(specify)</i>	су			2	3d. Date of delive Month	ery Day Year
Division or Vital Records, P.O.	signed by	by Phy	Part II. Other significant conditions cor	tributing to dea	th but not resu	ilting in the u	nderlying cause g	iven in Part I.					ne cause of death?
cord	v requir been si should I	eted								1 ∐ 24a. Was	Yes 2		
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Vita	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital:	patient 2 🗹	P ER/Outpatie	nt 3 DOA O	ther		Check only o		<b>T</b> 0	
J Or	ding Physician: n. After this certific funeral director,	n: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of		28b. Time o	" DOY	4 🗀 NUI:		J. Describe		Other (Specif	у)
isio	or Attendle after death. Director: Ai I in by the fu	icatic	2 Accident investigation 3 Suicide 6 Could not be	28e. Place o	of injury - At ho	me, farm, st		]Yes 2∏N		. Location (	Street and	l Number or Rura	al Route Number,
Div	ipital or Attenions after deathors after deatheral Director:	Certification:	4   Hofflidde				reet, factory, offic			City or To	wn, State)		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Examination		sis of examinat								
	To the complex	Me	29b. Signature and title of certifier  May L Swa	w	u, M:	D	Da	rse number + 369	0		07	e signed (Month,	12007
_	1. C. C.		30. Name and address of person who co	mpleted cause	of death (Item SHA) Sistrar's Signar	23a) (Type,	Print) n A Do	octors	Com	m. Ho	sp. i	-anhai	n, MD
	Sta Registi		31. Date filed <i>(Month, Day, Year)</i>	07	gistrar's Signa	K A	back						
DHM	MH 17 Rev 1/2	001				,							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 26 per phy aaco hlth dept 7/10/07 dlw State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Degetient's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OSBORNE **Physician** MBROSE 230 M 0 06 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1400 Lower View Court Crownsville Anne Arundel 7. Age (In yrs. last birthday) 81 yrs If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral**  Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 246-22-1820 Months Days Hours 100 M 2 🗆 F Director June 5,1926 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shedical Examiner must be notified MD Anne Arundel Gambrills 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 879 Claffy Ave. 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2X No ģ Specify: Specify: American Indian 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Tree Service Elementary/Secondary (0-12) College (1-4or 5+) Tree Surgeon 12 7 Is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Alvin Osborne 2 Callie Osborne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Osborne t of Health a Nephew 1400 Lower View Court Crownsville, MD 21032 : If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 7/9/07 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis Road Gambrills, MD 21054 Date Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate ha autopsy performed' funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: nechew's Medical Certification: To 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 5 🗆 Residence residence 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural s after de... ral Director: Afr 2 Accident 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Chief Medical Officer D 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, M.D., Hospice of the Chesapeake, 445 Defense Highway, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State JUL 1 0 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician ELLEN 1525 ROSE PIAZZA 2007 D /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE THE JOHNS HOPKINS HOSPITAL CIT 7. Age (In yrs. last birthday) II Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Director 216-60-4061 56 7 1951 WASH., DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Dapariment of Health and Mental Hyglene. importent: if item 27 is marked other then "neturef", or items 23a or 28a-f ehoven they injury or other traumatic event, the Madical Examinar must be notified at once. VA FRONT ROYAL 1 Yes 2 No Directo WARREN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 61 MILLDALE VALLEY CT. 22630 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WRITER U.S. AIR FORCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN C. ROSE, MD DOROTHY DONNELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD ROSE / BROTHER 19620 SELBY AVE., POOLESVILLE, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) STAUFFER CREMATORY 7/12/07 FREDERICK, MD 21. Signature of Fun al Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fungal Pheremonia **Physician** disease or condition resulting in death) INONTH /Medical Due to (das a consequence of): Examiner Acute wyelogenous
Due to (or as a consequence bl): 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physicien: The law requires that the death certificate be executed Exam end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death |Check only one) Hospital: 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 27. Manner of Death 1 (2 Natural tuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred After 5 Pending investigation ie Hospiter C., in 24 hours efter death. the Funerel Director: Aft 2 Accident 1 TYes 2 TNo 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Parolyn Clerso, MEXICA POCTIR RES-000 JULY, 10, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLYN ALONSO, THE JOHNS HOPKINS HOSPITAL, beconcribilities street, Bultimore Maryland 31. Date filed (Month, Day, Yar) 2 2007 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 01,04AM Harry E. Roberts, III 2007 July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Elkton Ceci1 65 South Forest Road If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 10X M 2□ F Director 69 AUG Pennsylvania 222-20-7153 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or Items 23s or 28s-1 show other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Directo Ceci1 Maryland Elkton 10e. Street and Number 10g, Citizen of What Country? 10f. Zin Code 21921 65 South Forest Road United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Ite any Injury or other treumatic event, Ite Modical Examina 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Instrumentation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry E. Roberts, Jr. Rita Hutchins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean M. Roberts/Wife 65 South Forest Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of commetery, crematory or other place)
R.A. Ferris &
Co., Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State July 19, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Chester, <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 2007 Pennsylvania 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, Maryland 21921 and B 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder Physician 2415 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Physician/Medicai IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown à cate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1 Yes 2 X No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗖 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident thei Director. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide within 24 hours a | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) pice 133 N. Bridge St. Saite & Elkton, MD 10 45 3 Registrar's Signature 31. Date filed (Mort) Pay, 2ear

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,  ${\cal E}$ 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #17 per FH 07-12-2007 Conficate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 3:5-6 essie. RUSE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6. Sex Dinder 1 Year | If Under 24 Hrs. to Tiblas Age (In yrs. last birthday If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 1 F 78 220-22-258 Yrs. 30,1928 OEC, NORTH CAROLIUM Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Dak 1 ⊈Yes 2 □ No GWYNN Director Md. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WINDSOR MILL ROAD 21207 5603 USA Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Specify: BLAUK Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ROSEWOOD d 2 should be filed within the and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) AIDE STATE CENTER HEALTH 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Simon O. Buie LOACH STHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. Gwynn Oan Md. 21207 Rose Mill John W. nusb 5603 Windsov 20b. Place of Disposition (Name of cometery, crematory or other place)

LORRAINE PARK Com. July 16, 2007 GWYNN DAK, Md. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 4. POLLINS FUN. a. 21701 110 WEST SOUTH MO ST FR606RICA 23a. Part1. Enter the digease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a Insequence f): disease or condition resulting in death) End /Medical Examiner Sequentially list conditions, if any, but high trimmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit the death certificate be executed Exami Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? be detached for Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No by the 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 1 Yes 2 No ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registra

29b. Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month. Dav. Year)

	1- State Registrar		partment of Health and M ertificate of Death	lental Hygier Reg. I		
Physicia	Anna Maa Sh	NSENBALICH		2. Date of Death Month	Day Year 3 2007	3. Time of Death
/Mediča	4 - 10 11 11 11 11 11 11		4b. City, Town, or Location of Death		4c. County of Death	1
	Fahrney-Keedy Home		Boonsboro		Washingto	on
Funeral Director	5. Social Security Number 6. Sex 1 ☐ M 2 ☑	7. Age (In yrs. last birthda 91 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes April 30,		ace (State or Foreign ry) Land
and	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10	d. Inside City Limits
Marylan f show	Maryland Washington	Hagers	stown			1 ☐ Yes 2√☐ No
ith the Ma or 28a-f	10e. Street and Number	1	10f. Zip Code	10g.	Citizen of What Count	ry?
th with	20009 Rosebank Way		21742		U.S.A.	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or itams 23s or 28s-f show aumatic event. It a Madical Examiner must be notified at	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. 1 I Forces? es 2 1 No , Give , or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2<sup>™</sup> No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: who	
21215-0036 ad within 72 hours aft glene. er than "natural, or it. I're Medical Everia	15. Decedent's Education (Specify only highest grade complet  Elementary/Secondary (0-12)  Colleg	ed) 16a. De (G. )////////////////////////////////////	cedent's Usual Occupation ive kind of work dorie during most of work a. DO NOT use retired)	ing 16b	. Kind of Business/Inde	ıstry
nd 212 e filed withi al Hygiene. other than	12	3 re	gistered nurse		hospital	
Baltimore, Maryland 2 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event.	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid		
rylano	Van Luther It:  19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street and Number or Rura	Elenora		Codel
Mal Ind 2 st Inth and 27 Is r	Julie Tosten - daughte:		Thomas Street, Hage			21740
re, N s 1 and f Health item 27	20a. Method of Disposition	20b. Place of Dis			. Location - City or Tov	
mori Pages nent of h	1   Burial 2 □ Cremation 3 □ Removal from the Superior of the	om State	ven Cemetery July	1707 Ha	gerstown,	Maryland
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or othe once.	21. Signature of Funeral Service Licensee			Minnich Fu	neral Home	1
<b>™</b> 89 € 28 91	tred L. Vesta		15 East Wilson Blv			
	23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death. Do not on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	Vastvente	ulml Seen			
Examiner	Due	to (or as a consequence or):				
	Sequentially list conditions, if any, leading to immediate Cause Disease or injury that initiated events	to o as a co sequence of):	)			
executed executed in and iiel-transit	Cause (Disease or injury that initiated events c	Stake				
6 exe	resulting in death) Last Due	to (or as a consequence of):				
68760, ilicate be executed g physician and as the burial-transit	d					
Box 6 sath certifications for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves 2   MAX   4   P.	regnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	y Day Year
P.O. that the de detached detached	9 ☐ Unknown 9☐ U	nknown				
ital Records, P.O. sian: The law requires that the de principale has been signed by the ctor. page 2 should be detached		to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ❷dfknown		
Secondary Page 12 Secondary Page 12 Secondary Page 12 Secondary Page 12 Secondary Page 13 Secondary Pa				24a. Was an autopsy	24b. Were autop	sy findings available ipletion of cause of
The is ate ha				performed 1 ☐ Yes 2	death? No 1 ☐ Yes 2	
Continues of the contin	25. Was case referred to medical examiner?			(Check only one)		
Of Of Phys	T Tes 21 No	Inpatient 2 ER/Outpar ate of Injury 28b. Time	tient 3 DUA 4 Nursing no	me 5 Residence 28d. Describe how in	6 Other (Specify)	
On o on o ding Pt th.	1 Avatural 5 Pending (f	Month, Day Year) Injur			,,,	
Division  I or Attending after death. Director: After din by the fune	3 ☐ Suicide 6 ☐ Could not be 28e. P	lace of Injury - At home, farm, uilding, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural	Route Number,
Divis  Divis  Divis  Hospital or Atte 24 hours after de Funeral Directs stely filled in by th			eath occurred at the time, date and place,	and due to the cause	e(s) and manner as sta	ited.
To the Hosp within 24 ho To the Fun completely (	(Check only 2 Medical Examiner: On the	ne basis of examination and/or nanner stated.	r investigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
To th within To th comp	29b. Signature and title of certifier		29c. License number		Date signed (Month, D	
	1 (and)		00050362	4	aly 16,	2007
93H-20	30. Name and address of person who completed	cause of death (Item 23a) (Type 29/1 ToFFortm	DO050362 De, Print) on Blad Smithubu	a Mar	land 31	723
Stat	31. Date filed (Month, Day, Year)	2. Bagistrar's Signature		11	4	
Registra	1111 4 - 0007	A. A.	hertes			

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

After this hours after death hin 24 hours af the Funeral C the

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William C. Maxted Jr. M.D. Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

JUL 1 0 2007

6 ☐ Could not be

32. Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

**ORIGINAL** 

1 ☐ Yes 2 ☐ No

2002 Medical Parkway Annapolis, MD 21401

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

13m375

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

# 07-05241

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

 . , , , , , , , , , , , , , , , , , , ,			
State of Maryla	and / Department of	Health and Menta	l Hygiene

onald Eugene		State of Maryla - For State tegistrar	nd / Department <i>Certificate</i>	of Health and Menta of Death		. No.			
Physicia	an/	1. Decedent's Name (First, Middle,Last)	· · · · · · · · · · · · · · · · · · ·		2. Date of Death		3. Time of Death 1326 hrs		
Medical Exami		Donald Eugen  4a. Facility Name (if not institution, give street and nur		4b. City, Town, or Location of I		4c. County of Death	1020 1113		
		Washington County Hospital		Hagerstown		Washington			
Funeral Director		578-92-4762 1XM 2F	7. Age (In yrs. last birthday	yrs. If Under 1 Year If Under 2  Months Days Hours	Min. 10/28/1	(MM/DD/YYYY) 9. Birti Foreigi .961			
an y	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits		
≱ .	ē	MD. Montgomery	German				1 Yes 2 X No		
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		10f. Zip Code	109	g. Citizen of What Coun	try?		
vith the s 23a o	aD	11708 Scarlet Leaf Circ1		20876  Was Decedent of Hispanic Origin	? ( Specify Yes or No-	United St			
death v	Funeral	1 Never Married 2 X Married Armed Fo	2 X No	If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)	White, etc.	. =		
s after	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No specify:	od of work done	Specify: Whi			
2 hour	Completed	15. Decedent's Education (Specify only highest grad  Elementary/Secondary (0-12) College (1-	durin	ng most of working life. DO NOT us		Willia of Business/ii			
036 vithin 7 ene. er than Medica	mpl	12	S	Self Employed		Constru	ction		
15-0 filed v il Hygi ed othe	Be Co	17. Father's Name (First, Middle, Last)		18.Mother's	Name (First, Middle, M				
212 212 ould be I Menta mark	To B	Kenneth L. Muth  19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street and Numb	Margare er or Rural Route Numb	per, City or Town, State	Zip Code)		
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Candace L. Via/Wife		08 Scarlet Leaf	Circle, Ge	rmantown, 1			
Ore, ges 1 ar of Hea If ite		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from	om State crematory of	sposition (Name of cemetery, or other place)					
Itim it. Pag utment ortant:		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	Metropol	itan Crematory  22 Name and Address of Facility	7/10/2007	Alexandria	, Virginia		
Balt permit. Depart Impor injury	7	Vokat H. W.	1	.0 East Deer Par	k Dr., Gai	thersburg,	MD. 20877		
Physician /Medical		23a. Pa 1. Enter the disease, or complications that ca fail i.e. List enty one cause on each line.	st, shock, or heart	Approximate Interval Between Onset and					
raminer		Immediate Cause (Final disease or condition resulting in death)  A Head and Control or condition resulting in death)	hest injuries consequence of):				Death		
		Sequentially list conditions, b.							
	iner	cause. Enter Underlying Cause	consequence of):						
cuted and transit	el Examine	events resulting in death) Last Due to (or as a d	consequence of):						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after the death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	UNPENDED AMENDED							
876 tificate ing phy as the	M/UE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, of the past 12 months?	outcome of pregnancy irth 2	Fetal death 3 Ectopic	pregnancy	23d. Date of delivery	Day Year		
Box 687 e death certific. the attending p ed for use as th	sicis	1 Yes 2 No 9 Unknown g Unknown	ant at time of death 5	Other (Specify)					
Division of Vital Records, P.O. Boy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for		Part II. Other significant conditions contributing to		the underlying cause given in Part	I. 23e. Did to	pacco use contribute to	the cause of death?		
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the staff ceath and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	d by					2 No 3 Prot			
ords w requ as been	Completed		_		24a. Was a autops	sy prior to o	topsy findings available completion of cause of		
Rec The la icate h	performed? death								
ital sician: s certif irector,	Be	25. Was case referred to medical examiner?	npatient 2 ✓ ER/Outpa	26.Place of Death (Catient 3 DOA Other		Residence 6 Other			
of Vital Recoling Physician: The law After this certificate has uneral director, page 2 s	1: To	27. Manner of Death 28a. Date	of Injury 28b, Time	e of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	collision		
ion ttendir death tor: A	atio	1 Natural 5 Pending Jul 8, 20 2 ✓ Accident Investigation		To les 2	10	cycle fixed object			
Divis al or A s after of I Directed in by	Certification:	3 Suicide 6 Could not be determined (Specify)	treet and Number or Ru ate) Frederick , MD	ral Route Number, City					
Hospita 4 hours funera ely fille		4 Homicide 29a. Certifier 1 Certifying Physician: To the bes	Interstate/Express	occurred at the time, date and place	e, and due to the cause	e(s) and manner as stat	ed.		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of and manner s	of examination and/or inves	stigation, in my opinion, death occ	urred at the time, date a	and place, and due to th	e cause(s)		
F > F 3	Me	29b. Signature and title of certifier	1	29c. License number		29d. Date signed (Mo	nth, Day, Year)		
10		laballa		O.C.M.E.		July 9, 2007			
		30. Name and address of person who completed cause Zabiullah Ali, M.D. Assistant Medic		Penn Street, Baltimore, M	D 21201				
	tate	31. Date filed (Month Pay, Year) 2007 32.	gistrar's Signatur	hout s					
Regis	trar	002 200.	MAN IN						

		Plea	se Type or Pri					•		_	
		1 - For State Registrar	State of M	arylan		ertificate of		wental ny	Reg. No		
		Negistrar     Name (First, Middle)	e, Last)				Douin	2. Date of D	eath	£	3. Time of Death
Physicia /Medic		Evelyr	1		Wis	e		July 1	6, 20	007 Year	1:20 pm <sup>M</sup>
Examin		4a. Facility Name (If not institution Record Street	_	)			or Location of Deatlederick	h	4c. County of Death Frederick		
Funeral Director		5. Social Security Number 214–10–2396	6. Sex 7. A	ge (In yrs. i 89	<i>last birthda</i> y Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Dec. 8	th ay, Year)	17 Mai	pplace (State or Foreign intry) cyland
pur 🔥		Usual Residence of Decedent  10a. State 10b. County		10c City	y, Town or L	ocation					10d. Inside City Limits
Maryla f sho	tor	· · · · · · · · · · · · · · · · · · ·	erick	reder						1 XYes 2 □ No	
with the 3a or 28a t be notif	I Director	10e. Street and Number 115 Record S	treet			10f. Zip Code	21701			tizen of What Co	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marr 3 ◯ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes ② If Yes, Give Year or Dates:	?	S. 13	14. Race - Amer Black, White Specify: Wh	, etc.				
72 hor natura fical E	eted	15. Deceden	t's Education st grade completed)	16a. Dec	edent's Usual Occu	pation during most of wo	rkina	16b. K	ind of Business/l	ndustry	
within jiene. r than " the Mec	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		e kind of work done DO NOT use retire Outer Pro		9	Go	vernmen	t
al Hyg	Be C	17. Father's Name (First, Middle,	,		•		18. Mother's Nar				
i Meni i Meni narkec	To	Maurice C. E						othy G.			
nd 2 sk alth and 27 Is n r traun		19a. Informant's Name/Relations Kevin Quirk, A		C		ling Address (Street Record S					ip Code)
ages 1 a ant of Heart I frem y or othe		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		C	emetery cri	position (Name of ematory or other pla vet Cemeter	y July 20.	Date 2007		ocation - City or	
permit. F Departme Importan any Injur once.		21. Signature of/Funeral Service		MOOO	2.1	22. Name and Addr Keeney and	ass of Facility  Bastoro	l PA Fun	eral	Home	1701
GF.		23a. Part1. Enter the disease, or	complications that cause	d the death		LO6 East on the mode of dy				K, PD 21	Approximate
Physician		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	Pneumo								Interval Between Onset and Death  1 Day
/Medical Examiner		Due to (or as a consequence of):									
red nsi <b>t</b>	Examiner										
e execuian and											
icate b physic s the b	dica	d									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)								very Day Year	
ires that t signed by d be detac	by	Part II. Other significant condition	ons contributing to death			underlying cause gi	ven in Part I.				the cause of death?
w requ	letec	Corona	ry Artery D	iseas	e			24a. Was			topsy findings available
cate has	Completed	Hypert	ension					auto peri 1□ Yes	opsy formed? 21 No	prior to death? 1 ☐ Yes	completion of cause of
sician certifi irector	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	Hospital:	ient 2 🗆	ER/Outpatie	ent 3 DOA Ot	26. Place of Dea			Domici XX Other (Spec	liary Care
ding Phy n. After this funeral d	-	27. Manner of Death  ↑ Natural 5 Pendin	28a. Date of In (Month, D	ury	28b. Time Injury	of 28c. Inju		dome 5 ☐ Res 28d. Describe			ony)
or Atten after deatl Director: in by the	Certification:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	not be 28e. Place of in	ijury - At ho etc. (Specif	ome, farm, s	street, factory, office	100 2010	28f. Location City or To			ral Route Number,
Hospital 24 hours : Funeral stely filled	edical Co	29a. Certifier (Check only one)  Certifyin  2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examina	wledge, deation and/or	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time	e cause(s e, date an	and manner as d place, and due	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifie		zel	2 1	29c. Licen D 3	se number 0496			ite signed (Month	
4		30. Name and address of person Francis E. Be					eet. Fred	lerick.	MD 2.	1701	
Sta Registr	-						,	,			

DHMH 17 Rev 1/2001

	1 - State Registrar				Ce	rtificate of	Death		Re	eg. No.		
ysician	1. Decedent's Name	(First, Middle, I		7 1.7 -	~~~			M	ate of Deat onth	Day	Year	3. Time of Death
ledical	4a. Facility Name (If	not inctitution		A. We:	rner	4b. City, Town,	or Location of E		7	4c. Co	2007 ounty of Death	
aminer	6	SAMARIT	41	ITAL		1 1	RALTIMUR					RE CITY
al	5. Social Security Nu			7. Age (In yrs.		If Under 1 Year Months Days		Hrs. 8. Da	ate of Birth fonth, Day,	Year)	9. Birth	place (State or Foreig
	212-07-		1 L M 2 LA F	9	2 Yrs.						914 M	laryland
	Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limit
To Be Completed by Funeral Director	Maryland	Balt	imore			Parkv	ville					1 □Yes 2 X No
Director	10e. Street and Num		21m010	·'		10f. Zip Code			1	0g. Citizer	n of What Cou	ntry?
ra a	7701 Oak	leigh			10		2123			U.S	. A . . Race - Ameri	oon Indian
Funeral	11. Marital Status 1 □ Never Marrie	od 2□ Marrio	Armed For		1.5.	Was Decedent of If Yes, specify Cu	ban, Mexican, l	Puerto Rican	es or No- , etc.)	14.	Black, White,	
þ	3 ₩idowed		d 1 ∏ Yes If Yes, Giv Year or Da	e Ates:		1 ☐ Yes 2 ☐ No	Specify:			S	<sup>rpecify:</sup> Whi	te
Completed	(Spec	15. Decedent's	Education grade completed)		16a. Dece	dent's Usual Occi	upation e during most o	of working		16b. Kind	of Business/Ir	ndustry
nple.	Elementary/Secon	ndary (0-12)	College (1	-4or 5+)		kind of work done DO NOT use retir				_	_	
S	8 th		ast)		C	afeteri		<u>oer</u> s Name <i>(Firs</i> :	t, Middle, N	FOO Maiden Su		
To Be	( ) ( ) ( ) ( ) ( )		Laurent	is Le	i kus		Anı	na Sai	kevi	CUS	,	
-	19a. Informant's Na			25_20		ng Address (Stree					own, State, Zi	ip Code)
	Ruth Re	stivo	/ Daugh	ter	7701	Oaklei	gh Roa	ad, B	alti	more	Mary,	land2123
Ш	20a. Method of Disp ₩ Burial 2 F	osition	Removal from S	State 20b. I	Place of Disponentery, cre	osition (Name of matory or other pi	lace)	Date	1	20c. Loca	tion - City or T	own, State
,	4 □ Donation	5 ∐ Other (Spe	ecify)	Мо				7/17/	07   1	Balt	imore	,Marylan
	21. Signature of Fu	100	7 //	_		2. Name and Add		Marzi	ullo	Fun	eral	Chapel,P
	23a. Part1. Enter th	ne disease, or or	omplications that ca	aused the dea	th. Do not en	009 Har ter the mode of dy	ford F ying, such as ca	Road, I ardiac or resp	Balt: Diratory arre	<del>imor</del> est,	e,Mar	Vland212
e l	Immediate Cause (I	rt fallure. List or Final	nly one cause on e	ach iine.		-	LEED					Interval Between Onset and Death
	disease or condition resulting in death)	` <i>"</i>	a Due to (	or as a consec	quence of):	SIGHL D	LEED					
	Sequentially list cor	nditions	b		TEN SIC	N.						
iner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	mediate rlying	Due to (	or as a consec	squence of).							
Examiner	that initiated events resulting in death) L	ast.	c Due to (	or as a consec	quence of):							
			d									
Physician/Medical				_								
an/N	IF FEMALE: 23b. Was decedent		23c. If yes, out 1□Live b	come pf pregn irth 2□Fet		⊒Ectopic pregnar	псу			23	d. Date of deliv	very Day Year
sici	in the past 12 1☐ Yes 2 5 9☐ Unknown			ant at time of		Other (specify)					Worth	Day real
Ph	Part II. Other signif	icant condition	s contributing to de	eath but not res	sulting in the u	underlying cause of	given in Part I.	2	3e. Did tol	bacco use	e contribute to	the cause of death?
d by									1 □ Y	es 2	No 3 ☐ Pro	bably 4 dunknow
Completed								2	4a. Was a	ın	24b. Were aut	topsy findings availab ompletion of cause of
шо								_	autops perfori	med? 2 No	death?	ompletion of cause of 2 ☐ No
Be C	25. Was case reference examiner?	red to medical				540	26. Place o	of Death (Che	_			
TO E	1 ☐ Yes 2 ☑	_				III JU DON					□Other (Spec	eify)
ü	27. Manner of Death 1 ☑ Natural	5 Pending		of Injury th, Day Year)	28b. Time of Injury	l W			Describe ho	ow injury (	occurred	
<u>#</u>	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	t be	of injury - At h	nome, farm, st	reet, factory, offic	□Yes 2□No		neation (S	treet and	Number or Ru	ral Route Number,
1.0	4 ☐ Homicide	determin	ed buildi	ng, etc. (Spec	ify)			20 6	ity or Town	n, State)	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,
ertific			Physician: To the			th occurred at the						
ical Certification:			xaminer: On the b		ation and/or i	nvestigation, in m	y opinion, dean					
Medical Certific		title of certifler	xaminer: On the b and man	asis of examination of stated.		) 29c. Lice	nse number		2		signed (Month	
Medical Certific	(Check only one)	title of certifler	xaminer: On the b	ner stated.	CIDENT	) 29c. Lice	nse number			7	1/12/07	

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Physicia /Medic Examin

**Funeral** Director

	Please Ty	pe or Print in Bla	ck Ind	elible Ink.	Ensur	e All C	opies A	re Legi	ible.		
	500	State of Maryland /	Depar	tment of H	ealth ar	nd Men	ital Hygid	ene			
	For State Registrar		Cert	ificate of L	Death		Red	ı. No.			,
	Decedent's Name (First, Middle, Last)					2. 1	Date of Death	, ,		3. Time of E	Death
n al	VICTORIA L	Jolland				J	Month	Day 13	2017	6:00	PM
er	4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, or	Location of	Death		4c. County	y of Death		
	Washington County	Hospital		Hagers	town			Wash	ingto	n	
	5. Social Security Number 6. Sex	7. Age (In yrs. last i		If Under 1 Year		4 Hrs. 8. I	Date of Birth (Month, Day, )	(225)	9. Birthp	lace (State or	Foreign
	219-80-5664 1 <sup>1</sup>	<sup>1 2 ▼ F   87</sup>	Yrs.	Months Days	Hours	Min. Ma	ay 29,1	.920 Pennsylvania			ia
	Usual Residence of Decedent						J			J	
	10a. State 10b. County	10c. City, To	own or Loca	ation					1	0d. Inside City	Limits
Funeral Director	Maryland Washington	n Hag	ersto	wn						1x Yes	2 No
Ire	10e. Street and Number			10f. Zip Code			100	g. Citizen of	What Coun	try?	
ᇛ	833 Georgia Avenue	е		21	740			U.S	.A.		
ner	11. Marital Status	. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin	n? (Specify	Yes or No-		ce - Americ		
Ŀ	1 Never Married 2 Married	1 ☐ Yes 2 【XNo		Tes, specify Ouba	Specify:	T derio i lica	11, 6(0.)				
þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	"	LITES ZLALINO	Specify: White						
Completed	15. Decedent's Educat (Specify only highest grade c		6a. Decede	nt's Usual Occupa	ation Jurina most o	of working	16	6b. Kind of B	Business/Ind	dustry	
ᄚ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	nd of work done of NOT use retired	)						
် ပြ	8	0		homemake					own l	nome	
Be	17. Father's Name (First, Middle, Last)				18. Mother's	`_	rst, Middle, Ma				
2	Dominic	DeVince		Mary Sue Volpe							
	19a, Informant's Name/Relationship (Type.	. Print) 1	9b. Mailing	ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
	Carol J. Montgomery	y - daughter	837 G	Georgia Avenue, Hagerstown, Maryland 21740							
	20a. Method of Disposition	20b. Place	of Disposit	position (Name of Date 20c Location - City or Town State							
	1	loval from State   Cedar	r Lawr	wn Memorial July 17, Park 2007 Hagerstown, Maryland						nd	
	21. Signature of Funeral Service Licensee		22.1	22. Name and Address of Facility Minnich Funeral Home							
	Tred & Vest		41.	5 East W	ilson	Blvd.	,Hager	stown,	Mary	land 2	1740
	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. D	o not enter	the mode of dyin	g, such as ca	ardiac or res	spiratory arres	it,		Approximate Interval Betw	een
	Immediate Cause (Final disease or condition	BilaTeizl	/ /	euwn(						Onset and D	eath
	resulting in death)	Due to (or as a consequence			2		~	-		-	
		Chrance OB	SMUC	Tive	(mo	nay	Dis	ease			
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):								
Examiner	that initiated events	Pulmonory	Fil	rusi's							
	resulting in death) Last  Due to (or as a consequence of):										
edical	d.										
<del>g</del>											
an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		Ectopic pregnancy					ate of delive		ear

Certification: To Be Completed by Physici

Medical

29b.

1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant at 9☐Unknown
Part II. Other significant condition	
Rheimaziand	An Trait

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4☐Pregnant at time of death

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

	conditions continuating to death but not resulting in the underlying cause given	11.1
Rheumai	Told Anguaitis	
ATrial	Fibrillation	

	24a. Was an autopsy performed? 1∐ Yes 2 ☑ No
_	

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25	. was case relent									ith (Check only one)	
	examiner? 1 ☐ Yes 2 ☐	10	Hospital	: 1 ☐ Inpatient	2 ER/0	utpatient	3 🗆 🛭	OOA Oth	ner:	I ☐ Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
27.	Manner of Death  1 Matural  2 Accident	5 Pending investigation		Date of Injury (Month, Day Ye		Time of Injury	М	28c. Inju Woi 1 [		2 🗆 No	28d. Describe how injury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - building, etc. (S	At home, fa	arm, street	, facto	ory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only	1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination	
one)	and manner stated	

edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (s)

one)  Medical Examiner: On the basis of examination and/or investored.	tigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(
Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
I am (ONO)	122261117	511. 13 70

Malle Vamille
30. Name and address of person who completed cause of death (Item 23a) (Type,
Francisco A Daniel Do

W-160 State Registrar

31. Date filed (Month, Day, Year) JUL 16 2007



	_	For State	State of Maryland	d / Depa		lealth and N	Mental Hyg	_	on a a a a a
Physicia /Medic			nders	007			2. Date of Dea Month July	24, 2007	3. Time of Death 3:15 PM
Examin Funeral Director	1			as <i>t birthday)</i> Yrs.		r Location of Death  Ltimore  If Under 24 Hrs.  Hours Min.	9 Date of Birth	1 11 11 11	
D	Director	Usual Residence of Decedent  10a. State 10b. County  M.C. Ba	Ltimore 10c. City	, Town or Loc					10d. Inside City Limits 1
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marith and Mental Hygiene. Important: If the Marith and Mental Hygiene. Important: If simarked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Di	1815 West Ave	12. Was Decedent Ever in U.9 Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		2122 Was Decedent of He f Yes, specify Cub.	22 dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	USA  14. Race - Ameri Black, White  SpecifyAme 1	etc. Cican
ed within 72 hou lygiene. ner than "natura nt, the Medical E.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12 yrs,	(ducation (ade completed) College (1-4or 5+)	(Give life. [	lent's Usual Occup kind of work done DO NOT use retired DSSING (	during most of wor d) Guard		16b. Kind of Business/Ir  Baltimo  Maiden Surname)	,
should be fill marked oth	To Be	17. Father's Name (First, Middle, Las Calvin Caudi:  19a. Informant's Name/Relationship	11	19b. Mailin	g Address (Street	Lula V	Valkin	er, City or Town, State, Zi	ip Code)
ges 1 and 2 t of Health a if Item 27 is or other tra		Allen Anders  20a. Method of Disposition  1 Augurial 2 Cremation 3	TRomoval from State	L lace of Dispo emetery, cren	sition (Name of matory or other place	Ave. Dur	Date y 28	Id. 21222  20c. Location - City or T  Timonium	
permit. Pa Departmen Important; any Injury once.		4 □ Donation 5 □ Other (Spec 21. Signature of Furieral Service Lice	1977	_	y Valley Name and Addre Onnelly 110 Sol		2007   l Home int Rd.	Of Dundal 21222	
Physician /Medical Examiner		23a. Part Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. RESPIA	i. Do not ente	er the mode of dyi	ng, such as cardiad	or respiratory an	rest,	Approximate Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	lical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. TRAUM Due to (or as a consequence)  Due to (or as a consequence)  d. Fall	nation	c Bre	-	Fair	CENTELORION APPROVED F	WEDICAL EXAMINER
law requires that the death certificate as teen signed by the attending phys 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у	- 1	23d. Date of deli Month	very Day Year
w requires that the d	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribute to Yes 2  No 3  Pro	
The te h	Completed						1□ Yes	osy prior to c ormed? death? 2 □ No 1 □ Yes	topsy findings available ompletion of cause of
	o Be	25. Was case referred to medical examiner? 1    Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐	FR/Outpatier	nt 3 DOA Ott	ner.	ath <i>(Check only o</i>	<i>ine)</i> dence 6 □Other (Spec	rify)
e de la la		27. Manner of Death 1 □ Natural 5 □ Pending 2 ☑ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju		T	now injury occurred	,
To the Hospital or Attendition 24 hours after death. To the Funeral Director: At completely filled in by the fur	Certification	3 Suicide 6 Could not 4 Homicide determine	building, etc. (Specification)	me, farm, str	eet, factory, office		City or Tow	MARY AVEILE	BALTIMORE,
Hosp 24 hou Fune rtely fil	Medical		Physician: To the best of my kno miner: On the basis of examina and manner stated.						
To the within 7 To the comple	Med	29b. Signature and title effertifier			29c. Licen:	se number		29d. Date signed (Month	
			o completed cause of death (Item	1 23a) (Type,				7/25/0°	140
Sta	at o	31. Date filed (Month, Day, Year)	4 MYOLARZ  22. Registrar's Signa	ture	740 EA	STEEN X	hE , R	KOTHERE )	40 21224
Registi		JUL 2 6 20	07 Bales 3	A Francisco	Carried St.				

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		Cer	tificate of l	Death	Reg.	No.	21373
F	Physicia	an	Decedent's Name (First, Middle, La Audi	st) Cey Juanita Ab	ernathy			2. Date of Death Month July 21,	Day OO7 Year	3. Time of Death 12:15 P M
*	/Medic Examin	al	4a. Facility Name (If not institution, give				Location of Death	oury 21,	4c. County of Deat	
			·	Avenue Apt.		Balt:	imore	0.0-4(0:4)	N/A	hala (0) 4
ì	Funeral Director				5. last birthday) 75 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye May 16,	1932 Ma	hplace (State or Foreign untry) ryland
	yland now at		10a. State 10b. County		ity, Town or Loc					10d. Inside City Limits
	he Mar 28a-f sl otified	Director	Maryland N/A	J.		_	timore	100	Citizen of What Co	1XQX'es 2 No
	ath with the 23a or 2 cust be n		10e. Street and Number 3838 Roland Aver			10f. Zip Code	2121	1	USA	
920	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in l Armed Forces? 1 □ Yes XX No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I□Yes 2∰No	ispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
15-003	n 72 hc " <b>natu</b> i edlcal	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	ation during most of work d)	sing   16	b. Kind of Business/	Industry
212	d withingiene.	omo	Elementary/Secondary (0-12) 6th	College (1-4or 5+)		emaker	·		In own ho	me
Maryland 2121	be d o d o	To Be (	17. Father's Name (First, Middle, Las John Dewey Gost		e (First, Middle, Mai tle McCan					
	4.73 d		19a. Informant's Name/Relationship James L. Abernathy	'''	19b. Mailin 3838	g Address (Street Roland	and Number or Rui Avenue Ap	ral Route Number, C bt. 1211 B	ity or Town, State, A altimore,	Zip Code) MD 21211
altimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition  1		Place of Dispose cemetery, cremetery, Cremetery	natory or other nlar	morial 7/		c. Location - City or monium, M	
Balt	permit. Departi Import any Inj once.	8 1	21. Signature Funeral Service Lice	Cumto m	ss of Facility NSS—Seitz S Road B	Funeral altimore,	Maryland	21211		
			23a Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	2		240				Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	equence of):	ardion	nyopata	4		years
	Examiner		Sequentially list conditions,	b			· · · · · ·			
	uted	Examiner	cause (Disease or injury that initiated events	Due to or as a conse	quence on.					
20	rificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):			-	•	
68760,	rtificate t ng physic as the t	Medical		▲d					-10 - 2	1.75
.O. Box	ath ce ttendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 WNo 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
<u>α</u>	res that the de igned by the a be detached f		Part II, Other significant conditions	contributing to death but not re	esulting in the ur	nderlying cause giv	ren in Part I.	23e. Did tobac	cco use contribute to	o the cause of death?
ords	w requires been sign should be	ted by						1 🗆 Yes	2 No 3 P	robably 4 Unknown
Il Records,	sician: The law r certificate has be rector, page 2 sh	Completed						24a. Was an autopsy performe 1∐ Yes 2 L	prior to	utopsy findings available completion of cause of s 2  No
Ĭ Z	Physician: Th r this certificate ral director, pac	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ဤ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	at 3 DOA Oth	or:	th <i>(Check only one)</i> ome 5 🔀 Residence	se 6 ∏Other (Sne	acify)
on or	ding Phys After this funeral dii	H- 1	27. Manner of De th  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju		28d. Describe how		iony)
Division or Vital	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determined	De Des Blace of injunt - At	home, farm, str cify)	eet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical C		hysician: To the best of my k miner: On the basis of exami and manner stated.						
	To the l	Me	29b. Signature and title of certifier	lung		29c. Licens	se number	29d	Date signed (Mon	th, Day, Year)
	107		30. Name and address of person who	completed cause of death (It	em 23a) (Type,	Print)	+ Tows	J 000 No	21204	- 1/- 200
Ē	Sta	ate	31. Date filed (Month, Day, Year)	32. egistrar's Sig						

07-05690

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

teven Laylon Be		State of Maryland / Departme	ate of Death		188	7 7.557
Physicia	F	egistrar  Decedent's Name (First, Middle,Last)	nic or Beatri	Reg. 2. Date of Death		3. Time of Death
Aledical Examir	11/4	Steven Laylon Berk		Month Di July 24, 200	ay Year 7	2237 hrs
		a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		40. Oddiky di Bodii	
		Upper Chesapeake Medical Center	Bel Air	The second second	Harford	halaa (Chata aa
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	11 1	MM/DD/YYYY) 9. Birt Foreig	n
Director	L	212-15-9547   1 x M 2 F   21	Yrs.	Jan. 15	5, 1986 <sup>661</sup>	<sup>Intry)</sup> Maryland
. á	-	Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.						1 Yes 2 X No
ryland a-f sh	용	Maryland Harford 5	Joppa 10f. Zip Code	10g.	Citizen of What Cour	ntry?
or 28	Director		21085	1.27	USA	
with the Maryland ms 23a or 28a-f sho be notified at once.		606 Twin Brook Lane  11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S		14. Race - Ameri	can Indian, Black,
leath y	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after de	by F	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:			hite
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	g [	(-p,	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel		6b. Kind of Business/I	ndustry
)36 thin 72 } than "1 edical F	plet	Elementary/Secondary (0-12) College (1-4 or 5+)				
5-003 led withi Hygiene. other th	Completed	12 No. 17. Father's Name (First, Middle, Last)	Maintenance 18. Mother's Nam	e (First, Middle, Mai	Lawn Car den Surname)	e
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be C	William Preston Berk	Annett	e Louise	Lavlon	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she unaite event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Print )	o. Mailing Address (Street and Number or	Rural Route Number	er, City or Town, State	, Zip Code)
and 2 shou lealth and N tem 27 is n traumatic		Annette L. Berk / Mother	606 Twin Brook Lane		Maryland	21085
ore, MC stand 2 stof Health an If item 27 ther trauma			of Disposition (Name of cemetery, ory or other place)	Date 2	20c. Location - City or	Town, State
More Pages 1: tent of H ant: If id			ngton Cemetery 7-	28-07	Darlingto	n. Maryland
Baltimore, permit, Pages 1 an Department of He. Important: If ite injury, or other tr		21. Signature of Funeral Service Licensee	22. Name and Address of Facility McComas Funeral H	ome, P.A.		
	_	23a. Palt 1. Enter the disease, or compileations that caused the death. Do no	1 50 W. Broadway, H	el Air. N	Marvland 2	1014 Approximate Interval
Physician 'Medical	- 1	failure. List only one cause on each line.	or enter the mode of dying, such as caldiac	or respiratory arrest	, SHOCK, OF HEAR	Between Onset and Death
aminer	1	Immediate Cause (Final disease or condition resulting in death)  Multiple Injuries  Due to (or as a consequence of):				
		b		15		
	亨	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  Underlying Cause (Disease or injury that initiated  Due to (or as a consequence of):				
vecuted and ransit		events resulting in death) Last  Due to (or as a consequence or).				
O, be exect sician an	lica	UNPENDED AMENDED				1
က ္ဆိုင္းမ	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	
687 certific	jan/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	nancy	Month	Day Year
Box 6876( death certificate the attending phy	/sic	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)			
that the deneloop by the detached		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		acco use contribute to	
, P.( res tha signed be det	d by			1 Yes	2 <b>V</b> No 3 Pro	bably 4 Unknown
ords, w requir is been s should	ete			. 24a. Was an		utopsy findings available completion of cause of
e law e has ge 2 sl	Completed			perform 1 ✓ Yes 2	ed? death?	es 2 No
Division of Vital Records, P.O. tal or steeding Physician: The law requires that the rape death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact		25. Was case referred to medical	26.Place of Death (Chec			
Vita hysicia this cer	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/O	outpatient 3 DOA Other Nurs	ing Home 5 R	esidence 6 Othe	er:
n Of ing Ph After t funeral	n: To	27. Manner of Death 28a. Date of Injury 28b. (Month, Day Year)	Time of Injury 28c. Injury at Work?		w injury occurred cycle auto collision	on .
ion fendin eath.	atio	1 Natural 5 Pending Jul 24, 2007 215 2 ✓ Accident Investigation	0 hrs 1 Yes 2 ✓ No			
VIS or At of At of At of the d	itic	3 Suicide 6 Could not be 28e. Place of Injury - At home, f	arm, street, factory, office building, etc.		reet and Number or R ite) ng Factory Road, ,	ural Route Number, City
Spital Di	Certification:	4 Homicide determined (Specify) Major Road / H				
Division of <sup>1</sup> To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one)  2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	nd due to the causer at the time, date ar	(s) and manner as sta nd place, and due to t	ited. he cause(s)
To the within To the comp	ledi	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Me	
	2	Downa Minant, M.D.	O.C.M.E.		July 25, 2007	, ,
6		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examine	r 111 Penn Street, Baltimore,	MD 21201		
	tate	31. Date filed (Month, Day, Year) 32. Sigistrar's Signature	1			
Regis		JUL 2 6 2007 Regue &	(grade)			
DHMH 17 Rev 1/2	2001	OF OF	RIGINAL			

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

/Medi		MARY ALI	CE TYLE	R BROWNE				JULY	23 <b>,</b>	2007	8:24A M
Exami	ner	4a. Facility Name (i	f not institution,	give street and number)		4b. City, Town,	or Location of Death		4c. County	of Death	
				ND HOSPITAL			INTON		PRIN	CE GE	ORGES
Funeral		5. Social Security N		5. Sex 7. Ag 1 ☐ M 2XXF	e (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Count	ace (State or Foreign ry)
Director		267 32 7 Usual Residence of			81 <sup>Y</sup>	rs.		AUG. 05,	1925	SOUT	H CAROLINA
land bw		10a. State	10b. County	-	10c. City, Town	or Location				10	d. Inside City Limits
Many f sho	ō	MD	DDINCE	GEORGES	יים זינונים	73111 4 34				10	1 ☐ Yes 2 TVNo
the tage	rect	10e. Street and Nu		GEURGES	CHELTI			1 4/	0- 000		
with a or		10707 ME		DT VE		10f. Zip Code		10	Og. Citizen of V		•
eath	era	10/0/ FIE	TNEPT DI	12. Was Decedent I	Ever in II S	2062			UNITED	STAT e - America	_
ter d iten	<b>Funeral Director</b>		ied 2 Married	Armed Forces?		13. Was Decedent of I If Yes, specify Cub	pan, Mexican, Puerto	Rican, etc.)		k, White, e	
al'; ol	þ	XX Widowed		d 1 ☐ Yes XX N If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Specify	BLA	CK
should be filed within 72 hours after death with the Maryland not Mental Hygiene. In a Medical Examiner must be notified at a matic event, the Medical Examiner must be notified at	Completed		15. Decedent's	Education	16a. E	ecedent's Usual Occu	pation	- 1	 16b. Kind of Bu	siness/Indi	ıstrv
7 nin 7. In "n Medi	ple	Elementary/Seco		grade completed)  College (1-4or 5		Give kind of work done ife. DO NOT use retire	during most of worked)	king			uotiy
d with	E	Licine hary, seco	11dary (0-12)	4YRS.		RECTOR			MODEL	CITIE	S PROGRAM
offlect of the control of the contro	Be C	17. Father's Name	(First, Middle, La	ast)			18. Mother's Nam	e (First, Middle, M			<u> </u>
uld bu dents rked rked	To E	JOHN H.	TYLER				SALLIE	MAE LASI	TER		
shot ind N	_	19a. Informant's Na	ame/Relationship	o (Type. Print)	19b. M	Mailing Address (Street				State. Zin (	Code)
alth a		LINDA BR	OWNE / I	DAUGHTER		707 MEYNELI		CHELTENH			
s 1 a f Hear item othe		20a. Method of Disp	position			Disposition (Name of crematory or other pla			20c. Location -		
age ent o nt: If			Cremation 3     □ Other (Spe	Removal from State	1		1			•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Fu	٠,	**	METROPO	DLITAN CREM	IATURY //2	6/200/	ALEXA	NDRIA	, VA
Depa Impo any i	10.0	1.	Y	lauskill		22. Name and Addre	S FUNERAL	HOME OF	MARYL	AND,	INC.
		23a. Parti Enter ti	he disease, or co	omplications that caused	the death. Do no		LAND ROAD		AND, M		4 6 Approximate
Dhusisian	١.,	Immediate Cause (	Final	ily one cause on each iln	e.			- respiratory and	-		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	n 💮		SNARY	EMBO	) L ) C 1 V L				
Examiner				Due to (or as a	consequence of)	:					
* *	i i	Sequentially list con	nditions,	b. — Due to (or as a	consequence of)	:	7			_	
nsit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	riying injury								
be executed sician and burial-transit	Ха	resulting in death) L	.ast	c Due to (or as a	consequence of)					_	
sicial buri							)				
rtificate ng physi as the I	edic			d							
the death certificate be executed y the attending physician and ched for use as the burial-transit	ysician/Medical	IF FEMALE: 23b. Was decedent	pregnent	23c. If yes, outcome p	of pregnancy				23d Date	of delivery	,
death a atte	icia	in the past 12 1 ☐ Yes 2	months?	1 ☐Live birth 4 ☐ Pregnant at	2 ☐ Fetal death time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		Mor		y Day Year
the ay the	Jysi	9 ☐ Unknown		9□Unknown							
The law requires that the de ate has been signed by the s page 2 should be detached	y P	Part II. Other signif	icant conditions	s contributing to death bu	t not resulting in th	ne underlying cause giv	en in Part I.	23e. Did toba	acco use contr	bute to the	cause of death?
quires n sign ald be	d by	LEFT	LUNG	CULLAPSE				1 ☐ Yes	3 2 □ No	3 ☐ Probai	bly 4 Onknown
w requ	lete	CORONA	2 Y A	HRTERY	BISEA	h=		Oda Was an	0.41- 14		F 1 2 1 1
he lav e has ige 2	Completed	Consider		/	10 14 LIT		<del></del>	24a. Was an autopsy perform	'   p	rior to comp eath?	sy findings available oletion of cause of
sician: The L certificate ha irector, page 3		SEVERE		MENTIA				1  Yes 2	<b>□</b> N₀ 1		□ No
sicia cert irectr	) Be	25. Was case referr examiner?  1 Yes 2		Hospital:		otient 3 DOA Oth	26. Place of Deatl				
Phys r this ral di	- To	27. Manner of Death		28a. Date of Injury	t 2 ☐ ER/Outpa / 28b. Tim	tient 3 BOA	4 L Nursing Ho	me 5 Resider 28d. Describe how			
ding F h. After funera	tion	1 ☑Natural 2 ☐ Accident	5 ☐ Pending investigati	(Month, Day	Year) Inju	ry Wor	k? Yes 2∏No	Zod. Describe flor	v injury occurre	eu .	
Attendi death. ctor: A y the fu	fica	3 ☐ Suicide	6 ☐ Could not determine	be 290 Place of injur	v - At home, farm	, street, factory, office		28f. Location (Stre	at and Numbe	ror Pum I I	Pareto Mumbas
after Dire	Certification:	4  Homicide	determine	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	City or Town,	State)	or riurar r	noute Number,
spita nours neral / fille		29a. Certifier	1 Certifying I	Physician: To the best o	f my knowledge, d	eath occurred at the til	me, date and place.	and due to the cau	use(s) and mai	ner as stat	ted.
e Ho r 24 h e Fu letely	Medical	(Check only one)	2 ☐ Medical Ex	aminer: On the basis of and manner stat	examination and/o	or investigation, in my o	ppinion, death occur	red at the time, da	te and place, a	nd due to t	he cause(s)
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, is	Me	29b. Signature and	title of certifier			29c. Licens	e number	290	d. Date signed	(Month, Da	ay, Year)
		D 200	No	PMYST	CIAN	DS	3782		JULY !	. ^	
2	-	30. Name and addre	ess of person wh	o completed cause of de					JULT.		2001
3		11701			LOAD ,	SUITE +	+101	FORT T	1) ASH	11V (- 7	FON. MS
Sta	te	31. Date filed (Monti	h, Day, Year)	32. Pagistrar		DVIIE T	, 101		011211		
Registr			JUL 26	2007	. K	Angell &					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3. Time of Death

Λ7.	-051	22

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1	10/	Bryant,	בו
iames	VV.	Brvant.	JK.

	•		1- For State Certificate of Death		Reg. No.	200	7 2.28					
	Physicia	an/	1. Decedent's Name (First, Middle,Last)	2. Date o	Day	Year	3. Time of Death 1520 hrs					
//	Exami		James W. Bryant Jr  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of		, 2007	. County of Death						
			329 East 20th Street Baltimore	Boutin	40.	County or Doda						
	Funeral		5. Social Security Number un 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		of Birth(MM/[		thplace (State or unk					
	Director		1 Ym 2 F 50 Yrs. Months Days Hours	Min. Mar	25, 19	957 Foreig	untry)					
	*	ļ	Usual Residence of Decedent				10d. Inside City Limits					
	ow any		10a. State 10b. County 10c. City, Town or Location Baltimore				1 X Yes 2 No					
	Maryland 28a-f show datonce.	흱	10e. Street and Number 10f. Zip Code		10g Citiz	zen of What Cou						
	te Mai or 28	Director	101 W. 23rd Street 21218				,					
	hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.		11. Mantal Status unk 12. Was Decedent Ever in U.S. 11 13. Was Decedent of Hispanic Original	in? ( Specify Yes	or No-		ican Indian, Black,					
	death r item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, 1 Yes 2 No	Puerto Rican, et	c.)	White, etc.						
	after	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:			Specify:	black					
	hours 'natul	P P	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give k during most of working life, DO NOT to the during most of working life.	ind of work done use retired)	unk 16b. K	and of Business/	Industry unk					
	0036 within 72 giene. her than "	ble	unk unk									
	15-0036 filed within 72 Hygiene. d other than ' the Medical	Completed		s Name (First, Mi	ddle, Maiden	Surname)	unk					
	21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Be										
	D 21 should and Me	٤	19a. Informant's Name/Relationship (Type, Print )			•	e, Zip Code)					
	imore, MD 2 Pages I and 2 shoul ment of Health and N tant: If item 27 is n or other traumatic	- 1	O.C.M.E. 111 Penn Street B 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		21201 Location - City or	Town, State					
	ges 1 at of H		1 Burial 2 Cremation 3 Removal from State crematory or other place)									
	Baltimore, permit. Pages I a Department of He Important: If ite	- }	Donation 5 X Other Specify: in state  21. Signature of Fronting and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  21. Signature of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  21. Signature of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  21. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility									
	Balt permit Depart Impor injury	ı		30ard 65 21201	5 W. B	altimore	e Street					
	ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. Nist only one cause on each line.	ardiac or respirato	ory arrest, sho	ock, or heart	Approximate Interval Between Onset and					
	-Medical Examiner		Immediate Cause (Final disease a. Narcotic Intoxication				Death					
			or condition resulting in death)  Due to (or as a consequence of):									
		힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	_	Examiner	C. Disease or injury that initiated experts resulting in death \ last \ Due to (or as a consequence of):				-					
	nted d ansit		events resulting in death) Last Due to (or as a consequence or):  d.									
	760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED									
	760, icate be physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy	N	230	d. Date of deliver	•					
	Ox 687 eath certific e attending for use as t	jan	past 12 months?	pregnancy		Month	Day Year					
	Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (Specify)		_							
	P.O. E es that the d igned by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I. 23e			the cause of death?					
	S, D	ed by		1			bably 4 Unknown					
	cords, P law requires t has been sign 2 should be c	Completed		24a	Was an autopsy	prior to	utopsy findings available completion of cause of					
	Rec The la cate h	ē		1 🗸	performed? Yes 2 N	death? lo 1 ✔ Y	es 2 No					
	tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other									
	of Vital Records, ng Physician: The law requir this certificate has been s neral director, page 2 should t	흔	examiner? 1  Yes 2 No	Nursing Home	5 Reside	ence 6 🗸 Othe	er: Scene					
	ision of Vital Records, P.O. Box 68: Attending Physician: The law requires that the death certifi r death r death. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as 1	<u>:</u>	1 Natural 5 Pending FOUND: Pound: FOUND: 1 Yes 2 ✓	Linknov		ary occurred						
		icat	2 Accident Investigation Jul 6, 2007   1520 hrs   28e. Place of Injury - At home, farm, street, factory, office building, etc.		ation (Street a	and Number or R	ural Route Number, City					
	Divis	Certification:	Suicide  4 Homicide  6 Could not be determined  (Specify) Vacant Building	or T 329 Eas	own, State) t 20th Stree	et, Baltimore, M	ID					
	= 4 = 5		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla									
4	To the Hos within 24 h To the Fun completely	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occard and manner stated.	curred at the time								
		Σ	29b. Signéture and title of cettifier 29c. License number 29d. Date signed (Month, Day, Yea									
critiq			( COVERNI)	( lclrlesw) O.C.M.E. July 7, 200								
			30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MDAssistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
	S	tate	31. Date filed (Month) Very Very 2007 32 Agistrar's Signature									
	Regis	.w.c	power to posses									

07-05027

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Christopher Morri		arrett St	ate of Maryla		rtment of tificate of		and	Menta	al Hyg	giene	D. N	201		
	F	legistrar 1. Decedent's Name (First, Midd	la l aet\		tilloate of	Death			2	. Date of D	Reg. No eath	0.	3. Time of Death	
Physicia Medical Examir										Month July 1, 2	Day 2007	Year	1850 hrs	
Medical Exami		Christopher M 4a. Facility Name (if not institution	on, give street and n	umber)	4	b. City, Tow	vn, or Lo	ocation of				4c. County of Deal	th	
		Rear of 1500 blk of N				Baltimo					j			
Freezen		5. Social Security Number unl		7. Age (In yrs. I	ast birthday)	If Under 1	1 Year	If Under	24Hrs.	8. Date of	Birth(MI	M/DD/YYYY) 9. B	irthplace (State or unk	
Funeral Director		ullip	i	52		Months	Days	Hours	Min.	Dec	19	1954 Fore	ign ountry)	
Bilector	L		1 XM 2 F	, , , ,	Yrs.					DEC		1754		
any	-	Usual Residence of Decedent  10a. Stateink 10b. County	un	z 10c. City.	Town or Location	on						unk	10d Hiside City Limits	
w a	-	Tour Grand III	an										1 Yes 2 No	
-f sh	후	40. 00. 10. 10. 10.			unk	10f. Zip Co	ode			unk	10a. C	itizen of What Co	untry?	
Mary r 28a	Director	10e. Street and Number				101. Zip G	ode			ulik	1	USA	,	
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t be r	Funeral	11. Wantai Otatas	12. Was De	cedent Ever in U Forces? U		Decedent es, specify (					NO-	White, etc.	main, Dack,	
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s afte raf", iner	ā		vorced If Yes, Give Ye						ind of wo	rk doness	n 1 <sub>c</sub> 16h	. Kind of Business		
hours natu Exan	8	15. Decedent's Education (Special Control of the Co		(1-4 or 5+)	during me	ost of working	ng life. I	DO NOT	ise retire	ed)	IIK		ulik	
36 n 72 nan "	bet	Elementary/Secondary (0-12		(1-4 01 5+)										
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Baltimore, MD 21215-0036  Secrify and 2 should be filed within 72 hours after death with the Maryland Departurent of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f show injury or other traumatic event, the Medical Examiner must be notified at once.	e Be	19a. Informant's Name/Relation	ship (Type, Print.)		19b. Mailing	Address	(Street	and Numi	ber or Ru	ıral Route	Number,	City or Town, Sta	ite, Zip Code)	
D 2 shou and N 7 is n	٩		J											
, MD and 2 sho ealth and em 27 is	ŀ	a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State												
altimore, mit. Pages I a partment of He portant: If ite			on 3 Removal	from State	crematory or oth	ner place)							·	
Pag Pag ment tant:	l	4 Donation 5 X Other S	Donation 5 X Other Specify: in/state											
Salt eparts inport		Konald S, Wade, Director State Anatomy Board 055 W. Ballimore Street												
<b>a</b> §§ ¶ iji	_	Jenny1	1/1 1414		lRa1	timor	ρ.	MD 2	2120	1			Approximate Interval	
Physician		23a. Part I. Enter the disease, of failure. List only one caus	e on each line.			ie mode o	uying, s	SUCIT dS Cc	ardiac or	respirator	y direct,	orioon, or rioure	Between Onset and Death	
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760, cate be physic the bur	/Me	IF FEMALE:	the T	s, outcome of pre	- common				_			23d. Date of deliv	rery Day Year	
6876 certificate nding phy	ian/M	23b. Was decedent pregnant in past 12 months?	1	e birth gnant at time of d	leath	etal death	3 [	Ectopic	pregna	ncy		Month	Day Teal	
Box e death o the atten	sici	1 Yes 2 No 9 U	alanaum ' H	nown	5 O	her (Speci	(iy)				-			
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S, quires en sig	Completed		-				-			24a.	Was an		autopsy findings available	
OFC aw reas be	ble										autopsy perform <u>e</u>		to completion of cause of i?	
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tal Rec	Be C	25. Was case referred to medi-				2	6.Place	of Death	(Check o	only one)				
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Division of Vital Records, is a for a strenging Physician: The law requirant Breach.  al Director: After this certificate has been shed in by the funeral director, page 2 should led in by the funeral director, page 2 should	T:u	27. Manner of Death	28a. Da	te of Injury nth, Day,Year) ID:	28b. Time of	Injury 2		ry at Work		28d. Desc Subject		injury occurred		
On endii sath or: /	itio		ending FOUN vestigation Jul 1,		FOUND: 1850 hrs	:	11	Yes 2 ✓	No					
/iSi r Att rer de irect	fica			ace of Injury - At	home, farm, stre	et, factory,	office b	uilding, et	tc.		ion (Stre		Rural Route Number, City	
Divisial o	Certification:			fy) Alley						Rear of 1	500 blk	N. Bond Street	, Baltimore, MD	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.		29a. Certifier	Physician: To the b	est of my knowle	edge, death occu	rred at the	time, da	ate and pla	ace, and	due to the	cause(s	and manner as	stated.	
To the Hos within 24 h	Medical	one) 2 Medical E	xaminer: On the bas	is of examination	and/or investiga	ation, in my	opinion	n, death oc	courred a	t the time,	date and	d place, and due to	o the cause(s)	
To To	ığ	29b. Signature and title of cert				29c.	Licens	e number			2	9d. Date signed (	Month, Day, Year)	
		Donna MU	mont N.T				O.C.	M.E.		July 2, 2007				
		30. Name and address of pers	•		em 23a)									
		Donna M. Vincenti,		t Medical Exa		1 Penn S	Street	, Baltim	ore, M	D 2120	1			
-	tate	Mar.	17.	Registrar's Signa	ature					-				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State amend 1 per Dr. g869 7/26/07 Caraticate of Death 1. Decedent's Name (First, Middle, Last) Wayne Rajesh Balroop, Jr. 2. Date of Death 3. Time of Death Month Year **Physician** 9 2007 04:18 A June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min Months 1XIM 2□ F June 9, MD Director 2007 None Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director Randallstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or USA 8511 Church Lane 21133 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Balroop Balroop Ariel Wayne and 2 sho.
annent of Health and Me
reportant: If item 27 is revision of other. 19b. Mailing Andress (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ST. 6701 N solornia 10WS AV 20b. Place of Disposition (Name of cemetery, crematory or other place) Date GROEN MOUN 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or 200 CREMATORY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Minutes disease or condition resulting in death) Prematurity /Medical Due to (or as a consequence of): Examiner Hours <u>Premature spontaneous rupture of membranes</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month for Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s performed' 2 No 2☐No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No 1 Mnpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 12, 2007 D30206 cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 6701 N. Charles St., Baltimore, Maryland Steven H. Pearlman, Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 6 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 56 AM ALFRED 23 200 GEORGE BEASLEY 6 /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** altimore 1705edale uare If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F Director 705-10-0833 MARYLAND 89 OCT. 1 1917 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1XXYes 2 No Director MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or "natural", or items 23a 18 AMBO CIRCLE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No if Yes, Give Year or Dates: 41/46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ Specify: 3 X Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT INSPECTOR 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ LOUIS BEASLEY ELLA MAE BEASLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Ambo Circle, Baltimore, Maryland 21220 Catherine Jones/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once, 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-30-07 OWINGS MILLS, MARYLAND GARRISON FOREST 22 Name and Address of Facily WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part1. Inter the disease, or com shock, of heart failure. List only or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician Due to (or is a consequence of): disease or condition resulting in death) /Medical Examiner holecyst.t. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the bunal-transi resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Failure 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 24a. Was an certificate 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home To Hospital: 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check s and manner stated. 29b. Signature a 29c. License number d title of certifie 29d, Date signed (Month, Dav. Year) WY JULY 23, 2007 D0060660 npleted ceuse of death (Item 23a) (Type, Print) 30. Name and address of person who GODD Franklir pal anka 31. Date filed (Month, Day, 32. Registrar's Signature Year) State 2007 Registra

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cian	Decedent's Name (First, Middle, La  BERNICE BEI	est) TON				2. Date of Dea Month JULY	Day	Year 2007	3. Time of Deat	th A <sup>M</sup>
lical iner	4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death	OOLI		ounty of Death	10:05	.1
	Washington Adver	tist		Takoma	Park		Mor	ntgomer	Z	
ıI		Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)		9. Birthp	lace (State or For	э <i>ign</i>
r	577-46-2375 Usual Residence of Decedent		73 Yrs.			Dec. 28	, 193	33 Wash:	ington, I	)C
	10a. State 10b. County	100	c. City, Town or Los	cation				1	0d, Inside City Lin	nits
to			Washingto	on D.C.					1 ∏Yes 2 □	No
Director	10e. Street and Number		,,asiiiii d	10f. Zip Code			10g. Citizer	n ol What Coun	try?	
ai	623 6th Street, N	E		2000	02			USA		
Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ☐ Yes 2\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\	1	☐ Yes 2 🛣 No	Specify:		Sp	pecify: Bla	ack	
	15. Decedent's E	ducation	16a. Deced	ent's Usual Occupa	ition		16b. Kind	of Business/inc	dustry	
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Son	9th	Ø	Hon	nemaker				Own Ho	ome	
Be	17. Father's Name (First, Middle, Las	")			18. Mother's Name		Maiden Su	ımame)		
2	Herbert Murray				Ida Joh					
1	19a. Informant's Name/Relationship  Cassandra Hairst			g Address (Street a			-		111	
	20a. Method of Disposition		Ob. Place of Dispos	Shenandoa Sition (Name of		Dellsv	•	tion - City or To	) 7 0 5 wn. State	
	XX Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, crem	atory or other place	*)     7/27/	(2007		_	, 5.5.0	
	21. Signature of Funeral Service Lice		Ivy Hill	Name and Address				cel, MD	P.A.	
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	23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the			·		<u> </u>		Approximate Interval Between	
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edic		0								
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. Il yes, outcome of pr		Ectopic pregnancy			230	d. Date of delive	ry	
sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time 9☐ Unknown		Other (specify)				Month	Day Year	
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þ	Part II. Other significant conditions  Seizure D	_	t resulting in the un	derlying cause give	n in Part I.		es 2□N		e cause ol death? ably 4 XUnkno	
etec		isorder				-	-			
ompleted					<del></del>	24a. Was a autop perfor	an 2 sy	24b. Were autor prior to cor death?	osy findings availa npletion of cause	of
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o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatient	Other	26. Place of Death	11.5		70tha= (C:	4	
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ertification;	3 ☐ Suicide 6 ☐ Could not be determined			et, lactory, office		28I. Location (S City or Tow	treet and N	lumber or Rura	Route Number,	
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edicai	(Check only 2   Medical Exa	nysician: To the best of my niner: On the basis of exa	/ knowledge, death mination and/or inv	occurred at the time estigation, in my opi	e, date and place, a inion, death occurr	and due to the d ed at the time, o	ause(s) an	d manner as st ace, and due to	ated. the cause(s)	
Med		and manner stated.		29c. License			_			
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≥ 1	29b. Signature and title of certifier		)	1	number > 6498		29d. Date s $7/2$	igned (Month, I	Day, Y	(ear)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) State JUL 2 5 2007 Registrar

2101 Medical Park Drive, Silver Spring, MD 32. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kashif Firozvi, MD

			For State		State o	of Mary	land /		rtment of F <i>tificate of</i>			ental Hy	_				
		-	Registrar Ame     Decedent's Name	end 7, per	rh,g809, /	//30/0/	TT	Cer	uncate of	Deal	<i>un</i>	2. Date of D	Reg. No	o i		3. Time of Dea	ath
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	/Medic Examin		4a. Facility Name (I.		ive street and nu		201-1		4b. City, Town, c	or Location		Jul		c. County	of Death		_
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	Funeral		5. Social Security N		Sex	7. Age (In			If Under 1 Year Months Days	If Und	re Min	8. Date of Bi	av Year	r)	9. Birthp	lace (State or Fo	reign
_	Director		218- 09 -		1∏M 2□F	92	93	Yrs.		1.00		Sept. 2	2 19	14	Mar	yland	
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	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notifled at		1005 Dur	ndalk Av					2122	4				U	S.A.		
	r dea	Funeral	11. Marital Status		12. Was Dec	edent Ever orces? 1 9	in U.S. 142	13. V	Vas Decedent of H Yes, specify Cub	lispanic an, Mex	Origin? (Spe	cify Yes or N Rican, etc.)	0-		e - Americ		
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y	Duid by Ment arkec	은	Peter		J.		Вι	urke		Ka	therin	ie			Ry	an	
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation  21. Signature-of F⁄a	5 Other (Specineral Seffice Lice		S	Sacre	d He	art of M. Name and Addre	ary	2007					y1and	
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>	/sicia	o Be	examiner?		Hospital:	Inpatient	2 🗆 ER/O	utpatient	3□ DOA Oth		Nursing Hom			e 🗆 Oth	or /Coosif	d.	
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	~ × 1		30. Name and addr	ess of person who	o completed caus	se of death	(Item 23a)	(Type, F			,		11	- 3	i -	1	-
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# Baltimore. Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

			Please	Type or Pri							_egible.	
		For State		State of M	aryland / [	-			l Mental Hy	giene		
$J_{ij}$	-	Registrar	ne (First, Middle, La	ct)		Certi	ficate of	Death	2. Date of D	Reg. No.		3. Time of Death
Physic			LIZABETH	,					Month JULY	24,	2007	11:25 A.M
/Medi Examir		4a. Facility Name (	If not institution, giv	e street and number)		4	lb. City, Town, o	r Location of Dea	ath		County of Death	
	4 19			JRSING CEN				MORE CI			N/A	
Funeral		5. Social Security N			je (In yrs. last bir 97		If Under 1 Year Months Days	If Under 24 Hi	n. (Month, D	av. Year)	9. Birth	place (State or Foreign ntry) YLAND
Director		217-36-4 Usual Residence o			71				9/13/	1909	MAR.	YLAND
arylan show	_	10a. State	10b. County		10c. City, Tow	n or Locat	tion					10d. Inside City Limits
he Ma 28a-f s	Director											1 ☐ Yes 2 🙀 No
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dieal Examiner must be notified at												ntry?
death	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. Wa			(Specify Yes or No erto Rican, etc.)		4. Race - Americ	
or Ite			ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No		es, specify Cub. ☑Yes 2【☑No	an, mexican, Pue	эпо нісап, етс.)		Black, White, Specify: WH	
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p it	iner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate erlying	Due to (or as	a consequence	of):						
executed in and ial-transi	Examiner	Cause (Disease or that initiated events resulting in death) !	5	c	a consequence	of):						
be licia	-			Due to (or as	a consequence	01).						
The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medica			d								
th cerr endin	an/M	IF FEMALE: 23b. Was deceden		23c. If yes, outcome	pf pregnancy 2 ☐ Fetal death	3 □ E	ctopic pregnancy	,		20	3d. Date of delive	ery
e dea the att	sicia	in the past 12	No	4□Pregnant at			ther (specify)				Month	Day Year
that the		9 ☐ Unknown	/ /	ontributing to death b	ut not resulting in	n the unde	rlying cause giv	en in Part I	23e Did	nhacco us	se contribute to t	he cause of death?
w requires that the de been signed by the s should be detached	d by			onthibuting to doubt b	acriot resulting in	ir tric dride	mymg oddae giv	en in r air i.				pably 4 Munknown
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The lav te has age 2	omp		11/10						- auto	psy prmed?	prior to co death?	mpletion of cause of
ian: ortifica	Be C	25. Was case refer examiner?	red to medical					26. Place of De	1  Yes eath (Check only o	2 <b>Ж</b> No   оле)	1 ☐ Yes	2□ No
Attending Physician: r death. ector: After this certific by the funeral director,	To	1 □ Yes 2 <b>5</b>		Hospital:			3□ DOA Oth	4 Nursing	Home 5 ☐ Resi	dence 6	□Other (Specif	(y)
ding F	ion:	27. Manner of Deat	h 5 ☐ Pending investigation	28a. Date of Inju (Month, Day		Time of Injury	28c. Injur Worl	yat k? Yes 2 ∐ No	28d. Describe	how injury	occurred	
Attender death	ficat	2 ☐ Accident 3 ☐ Suicide	6 Could not be determined	28e. Place of inju	ury - At home, fai	ırm, street		res Z INO	28f. Location (	Street and	Number or Rura	al Route Number,
s after	Certification:	4  Homicide	goternineg	building, et	c. (Specify)		•		City or To	wп, State)	77311207 07 77476	, riodio ridinos,
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only	1 Certifying Ph	ysician: To the best niner: On the basis o	of my knowledge	e, death o	ccurred at the tir	me, date and pla	ce, and due to the	cause(s) a	and manner as s	stated.
thin 24	Medical	one) 29b. Signature and		and manner sta	ated.		29c. License		odired at the time,			
Twit O O		29b. Signadire and	100 ve	1/0	. ~ 1	1-1)	29C. Licens	200	2 >	29d. Date	signed (Month,	Diy, Year)
0	-	30. Name and addr	ress of person who	completed cause of d	eath (Item 23a) (	(Type, Prir		500	<u> </u>	_//	00	, ,
7		I. Inc	21/2 E	7615.	1/1611	Um	n) /	n Sh	Ohm	NI	41) ô	1004
Sta		31. Date filed (Mon	th, Day, Year)	32. Registra	ar's Signature	Jack!	,	. (				
Registr				July 101	J. Pil	The state of the s						

		For State Registrar	State of Ma	aryland		artmer <i>rtifica</i> i					IENE eg. No.	January Company of the Company of th	
Physicia		Decedent's Name (First, Middle, La HORTENSE		COOPE	םי					2. Date of Deat Month	Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, gi		COOPE	ıK	4b. City	, Town, or	Location		uly		007 ty of Death	3:15 p
Funeral				e (In yrs. la	as <i>t birthday)</i> Yrs.	If Unde Months	r 1 Year	IMORF If Under Hours	24 Hrs. 8 Min.	B. Date of Birth (Month, Day,	Year)	9. Birth	
Director		215-24-3827 Usual Residence of Decedent		94					A	.UG 30	1912		RYLAND
Marylar f show led at	lor	10a. State 10b. County  MARYLAND BALT	IMORE	10c. City	, Town or Lo	ecation	DATO	TMODE	7				10d. Inside City Limit 1 □ Yes 2/□XN
th the or 28a-	Director	10e. Street and Number	IMOKE	<u> </u>		10f. Zi	p Code	IMORE	2	1	0g. Citizen of	What Cou	ntry?
sath wi	Funeral [	10 SQUANTO CT	12. Was Decedent B	Ever in 116	2 112	Was Door	212		lain? (Cnoo	it. Van as Na	U.S	. A .	oon Indian
urs after d al"; or Item Examiner	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 Xi  If Yes, Give  Year or Dates:			if Yes, spe		Specify:		ify Yes or No- ican, etc.)	BI	ack, White,	etc.
If a land 2 should be filed within 72 hours after death with the Maryland st H and 2 should be filed within 72 hours after death with the Marlal Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	Completed	15. Decedent's Elementary/Secondary (0-12)	Education ade completed) College (1-4or 5	+)		kind of wo DO NOT u	ork done d ise retired	during mos ()	st of working		16b. Kind of		·
filed w Hygier other th		7th grade  17. Father's Name ( <i>First, Middle, L</i> as	t)		F'AC'	TORY	WORK		er's Name (	First, Middle, M			FACTORY
d 2 should be file th and Mental Hy 77 is marked oth traumatic event	To Be	GEORGE MEEKINS						JOH	IANNA	MEEKINS	5		
and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship  Lewis Foust/ Go	, ,		I					Route Number e . Mary	•		o Code)
ges 1 ar it of Hea if item 2		20a. Method of Disposition  1 \( \) Buriat 2 \( \) Cremation 3 [		20b. PI	ace of Dispo	sition (Na	me of		Da		20c. Location		own, State
permit. Pages 1 a Department of Hee Important: If item any injury or othe		4 Donation 5 Other (Special Signature of Foneral Sequiposition		SHA	RP ST	REET 2. Name a			07-26	-07	CHASE,	MARY	LAND
perm Depa Impo any i		1/2	Juoun		W	ILLIA 321 S	M C	BROWN LADEI	COMM	BLVD, A	ABERDE.		FORD,P.A. D 21001
Blandala		23a. Part Free We diseas, or conshock, or heart failure. List only Immediate Cause (Final	nplications that caused one cause on each lin	the death ne.	. Do not en	ter the mo	de of dyin	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	a consequ	ence of):								
uted d	Examiner	Sequentially list conditions, if any Leadin L. immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for as:	a conse u	pence of):						-		
ficate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	a consequ	ence of):								
attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3[	⊒Ectopic p ⊒ Other (s			_			ate of deliv	ery Day Year
w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death bu	ut not resu	Iting in the u	nderlying o	cause give	en in Part I	l.		es 2 No		he cause of death?
The law recate has bee	Completed									24a. Was ar autops perform 1 Yes 'Y	v l	. Were auto prior to co death? 1 \( \text{Yes}	opsy findings availa impletion of cause
ysiclan: The second sec	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ Vo	Hospital:	00	-5/0		Othe		,	Check only on	-		
ding I. After fune	tion: To	27. Manner of Death    Taketural   5   Pending   2   Accident   investigation	28a. Date of Injui (Month, Day	ry	ER/Outpatier 28b. Time o Injury		28c. Injun Worf	DISTRIC	28	e 5 Reside			fy)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	De 290 Place of iniu	iry - At hoi c. (Specify	me, farm, sti	eet, factor	ry, office		28	f. Location (St City or Town	reet and Nun n, State)	ber or Rura	al Route Number,
Hospi 4 hou Funer ely fill	Medical (	29a. Certifier Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner sta	examinat	vledge, deat ion and/or ir	h occurred vestigation	d at the tin n, in my o	ne, date ar pinion, dea	nd place, ar ath occurred	nd due to the ca	ause(s) and r ate and place	nanner as s e, and due t	stated. to the cause(s)
To the within 2.	Me	29b. Signature and five of certifier				29	c. License	e number		29	9d. Date sign	ed (Month,	Day, Year)
$\sim u$		1980					DG	17	3 (		7/2	24/	7
2)4		30. Name and ad ress of person who	completed cause of de (Adeni Mb. 9	eath (Item	23a) (Type,	Print) Medin	Cia	ens	Dr. A.	312.7	Batts.	MD 0	21237
Stat	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure	0.09	0	V-110	12 10			1712	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 11:57P <sup>M</sup> DORIS C. CAULEY 2007 JULY 22. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Davs 1 M XX F Months Hours 19, 1935 Director 578 50 8626 DEC. WASHINGTON, DC Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes XX No Director MD PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 8424 GRANDHAVEN AVENUE 20772 UNITED STATES Funeral death 'natural', or items dical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. Specify: BLACK Be Completed by 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH CONTRACT\_SPECIALIST FEDERAL GOVERNMENT Ith and Mental Hygie
7 Is marked other traumatic event, th marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ GEORGE SELLMAN OLIVE HUDGINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If Item 27 any injury or other troonce. KEITH CAULEY / SON 617 NORTH BESTGATE ANNAPOLIS, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) MARYLAND VETERANS CEM. 7/27/2007 CHELTENHAM, MD 21. Signature of F@eral Service Licenses 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, Y lans 4308 SUITLAND ROAD SUITLAND, 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest, irratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exist to for as a nonsequence of) Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown X9X Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes XX No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 DN 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred : After t Hospital or Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) Day, Year) MM completed cause et death (Item 23a) (Type, Print)

State

30. Name and address of person w

2 6

Registrar DHMH 17 Rev 1/2001 gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend, item 30 per dvr e869 7-26-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 12:45 PM 20 Wayne J. Calvert 2067 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Yea May 18, 19 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ₹ M 2 □ F Maryland 1934 Director 219-28-3731 73 Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2√ No Directo MD Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Aiken Avenue 21903 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: þ Specify: white 3 Widowed 4 □ Divorced Completed injury or other traumatic event, the Medical illed within 72 h Hygiene. other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If Item 27 is marked other tha 12 car dealer automotive Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson Levering Calvert Erma Marie Kraft Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arnie Calvert/son 706 Aiken Avenue Perryville, MD 21903 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens Ronald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed MOV attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1□ Yes 2♣N 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No **Division or Vital** Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 🌉 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapeake Medical Center Mohammad Afzal 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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**Funeral** Director

72 hours after traumatic event, the Medical should be filed within 7 and Mental Hygiene.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

executed burial-tran attending physician pe as the l use signed by the a certificate has funeral director, this After

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **Physician JASON** 2007 ERIC COHEN 2:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2802 BAUBLITZ ROAD OWINGS MILLS BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days ntry) MD 1X M 2□F 04/12/1968 39 213-62-0753 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐Yes 2 No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2802 BAUBLITZ ROAD 21117 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No WHITE 1 ☐ Yes 2 🛣 No Specify Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER NUTRITION 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be COHEN STEINBERG **EDWARD** CAROLYN ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 BAUBLITZ ROAD, OWINGS MILLS, MD 21117 JESSICA COHEN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State HAR SINAI CONG. 07/24/2007 OWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MELANUMA MALIGNANT Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 9 Hospital or Attendi 24 hours after death. 9 Funeral Director: A death. 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES COHON 6569 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JUL 26 Registrar 2007

			For State Registrar	State of M	laryland	•	rtment of F tificate of	lealth and N Death		giene Reg. No.	IQ Ţ	11993		
	Physici	an	1. Decedent's Name (First, Middle, Last)	Carson					2. Date of Dea Month July	Day	2007	3. Time of Death 1:00 A <sup>M</sup>		
gr.	/Medic Examin		4a. Fecility Name (If not institution, give s Harborside Health		)			r Location of Death	oury		ounty of Death	1.00 //		
	Funeral Director		5. Social Security Number 6. Sex 217-05-3197	M 2⊠F	ge (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 0 1 28 -	9. Birthplace (State or For Mary Tand				
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltime	ore	10c. City, 1	Town or Loc	ation eland				1	0d. Inside City Limits 1 ☐ Yes 2 No		
	s with the h	Funeral Director	10e. Street and Number 21201 Millers Mill	Road	1		10f. Zip Code	1053		_	n of What Cour	ntry?		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other then "natural", or items 23s or 28s-f show eumatic event, the Medical Examinar must be notified at	by Funera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Specify Cuban  1 Yes 2 No If Yes, Give Year or Dates:					lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify:			
Maryland 21215-0036	within 72 hounde.	To Be Completed b							sing		of Business/Ind	dustry		
and 2	uld be filed v fental Hygie rked other t ilc event, to		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  Telitha Rower's											
, Mary	permit. Pages 1 end 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic engo.		19a Informant's Name/Relationship (Ty) William H. Rufenac	oe, Print) ht - Nep	hew	1361	01d Wate	and Number or Ru r Oak Po	nt Road	Pas	adena,	MD 21122		
altimore,	ment of H tant: If iter		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		Park	netery, crem KWOOD	ition (Name of latory or other pla Cemeter)	07/2	Date 5/2007		tion - City or To	Maryland		
Bal	Departition Depart	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, N  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.									ford Roe, MD	pad 21214 Approximate		
	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each	s a conseque	3		ig, such as cardiac	or respiratory a			Interval Between Onset and Death 1—2 days		
8760,	icate be executed physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a conseque									
P.O. Box 68	The law requires that the death certifics to has been signed by the attending phage 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown							230	d. Date of delive Month			
	w requires that i been signed by should be deta	5	Part II, Other significant conditions cor	tributing to death	but not result	ing in the un	derlying cause gi	ven in Part I.		obacco use Yes 2 🗆 I		he cause of death?		
Division of Vital Records,	: The law recate has bee	Completed							24a. Was auto perfo 1 Yes		24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	ppsy findings available mpletion of cause of		
of VII	Physician this certifi al director	To Be	25. Was case referred to medical examiner?  1 Yes 2 Wo  27. Mayner of Death	lospital:		R/Outpatient	3 DOA		th (Check only of ome 5 Resinguity Resinguit	dence 6[		(y)		
Vision	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of In (Month, D		Injury	28c. Inju Wo M 1 eet, factory, office	rk? ]Yes 2 □ No	~-···	Street and I		al Route Number,		
ā	fospitel or t hours afte unerel Die ely filled in		29a. Certifier 1 Certifying Phys	sician: To the bes	st of my knowl			me, date and place	, and due to the	cause(s) ar				
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)  29b. Signature and title of a rtifier	and manner s	molp	m	29c. Licen				signed (Month,			
(	81		30. Name and address of person whereo	empleted Juse of	death (Hem 2	23a) (Type, 1	Print) Bal	timole	. 66	1-2	123	39		
	St Regist	ate rar	31. Date filed (Month, Day, Year)		strar's Signatu	re Sp	with the							

			For State Registrar	State of Marylan	-	artment of H <i>rtificate of L</i>		-	giene Reg. No.	m rX	70 n.h.l.
D	Dharatal		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath •	, V	3. Time of Death
	Physici /Media		William A. Di	onne				JULY TULY	24	Year 2007	341 P.M.
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
	-	T AS		RITAN HOS	PITAL	BALT	TIMORE	=		N/A	
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da SEP 28	th y, Year)	9. Birthpl Coun	lace (State or Foreign try)
	Director		Usual Residence of Decedent	<sup>IM 2∐F</sup> 59	Yrs.			SEP 28	1947	New 1	Hampshire
hand	at ow		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				11	Od. Inside City Limits
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th with	23a o st be	<u>=</u>	4702 Valleyview Av	enue		21206			U	SA	
deat	ems :	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No	- 14. Rad	e - America	
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n 72	ı "nat edic∞	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	I (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of worki	ng	16b. Kind of B	usiness/Ind	ustry
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ald be	if Health and Micrital Hygjene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	.O.	Maurice Dionne				Jeannet	te C	ole		
shou	s mal		19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailii	ng Address (Street a	nd Number or Rura	I Route Numbe	er, City or Town,	State, Zip	Code)
C, W	er tra		Alicia L. Dionne -	wife	4702	Valleyvie	w Avenue,	Balti	more, M	212	206
es +	of of Hea If item ( or other		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Re		Place of Disponentery, crea	sition (Name of matory or other place	e)	ate	20c. Location	City or To	wn, State
Pages	ment tant: I		4 □ Donation 5 □ Other (Specify)		tro Cre	ematory, ]	Inc. 7/26	/2007	Baltim	ore,	MD
permit.	Department of Himportant: If ite any njury or ot once		21. Signature of Funeral Service License Stewer	ήμ. Williams	22	Name and Address Crematio 299 Fred	s of Facility n Society	of Mar	rvland.	Inc.	
ا م			8 Auci	W		299 Fred	erick Roa	d, Bal	timore,	MD 2	21228
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	HEART	FA	ILURE	DUE	TD	ANIEM	1/4	Oliset and Death
	aminer			Due to (or as a consequent	uence of):						
		-a	Sequentially list conditions, b	Due to (or as a conseq	uenes effi:						
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	as th	/ledi	IS SERVICE								
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e dea	he at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d 9□Unknown		Other (specify)			Mo	onth [	Day Year
at th	ed by the detached	Physician/M	9 Unknown		data a faraba			Ilas Biii			
The law requires that the death certif	pe ji	bý	Part II. Other significant conditions con	tributing to death but not rest	uiting in the ui	nderlying cause give	n in Part I.				e cause of death?
redu	been si should b	sted				· · · · · · · · · · · · · · · · · · ·		1 1	′es 2 No	3 Proba	ably 4 Onknown
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Attending	an: : After the s funeral	ţi	Dending  Accident  5 Pending investigation	(Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	? es 2 □ No	.04. 2000112011	ion injury occur	eu	
Atter	ector by the	ifica	3 Suicide 6 Could not be determined	28e. Place of injury - At ho	me, farm, str	eet, factory, office	2		Street and Numb	er or Rural	Route Number,
ial of	al Dir	Certification:	4   Hornicide	building, etc. (Specify	<i>(</i> )		-	City or Ton	n, State)		
lospi	uner uner	cal (	29a. Certifier Certifying Phys	ician: To the best of my knower: On the basis of examina	wledge, death	occurred at the time	e, date and place, a	and due to the	cause(s) and ma	inner as sta	ated.
the P	within 24 hours after death.  To the Funeral Director: After completely filled in by the fur	fedical	1	and manner stated.							
2	<b>2</b> 0	Σ	29b. Signature and title of certifier	MD		29c. License	S OO (		29d. Date signe	I (Month, D	Day, Year)
	11	-	10-10-						1/2	11	7
io			30. Name and address of person who con RENU GIUPTA,	mpleted cause of death (Item  MD GDOD	23a) (Type,	Print) ARITA	N HUSF	MAL	13ALT	11401	KE, MD
	Sta	te	31. Date filed (Month, Day, Year)	32 Relistrar's Signa	huro						
	Registra		JUL 2 6 20	107 Legue	B. A	partie					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200 7 24 Bernard Frank DiAngelo Jr. 1011 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Square Oseda TIMORE anklin 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Director 216-52-7210 July 12 1954 Pennsylvania Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan De artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumalic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Harford Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2349 Pennington Road 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married & Married 1 ☐ Yes 🏖 No þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Manufacturer Incinerator Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Frank DiAngelo Sr. Jean (nmn) Peshok 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. DiAngelo/Wife 2349 Pennington Road, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 7-26-07 Towson, Maryland 2. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee ussell S 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alveolar **Physician** Interstitial Preymonia 2 week pamage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 □Unknown 2 □ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 1 Yes 1.7 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manyrer of Death 28b. Time of After Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending within 24 hours after common to the Funeral Director: Aft investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, mo. 21237 rappedee State Registrar

			For State Registrar	State of Mary		epartment of F Certificate of I			giene Reg. No.		9990
	Physici		Decedent's Name (First, Middle,  Beula	,	esie			2. Date of Dea	Day	Year 0 7	3. Time of Death 9:50p M
•	/Medio Examir		4a. Facility Name (If not institution, Stella MAri			4b. City, Town, o	r Location of Death		4c. County Balt	of Death	re
	Funeral Director		5. Social Security Number 218-18-6324	1 M 2 THE	n yrs. last birth	rs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Oct. 2	, Year) 9, 1924	9. Birthp Coun Mar	lace (State or Foreign try) yland
•	show	'n	Usual Residence of Decedent  10a. State 10b. County  MD Balt	imore	oc. City, Town	or Location 1timore				1	0d. Inside City Limits 1 ☐ Yes 2 🗷 No
	with the Na or 28a-1	I Director	10e. Street and Number 7467 Berkshi			10f. Zip Code 21224			10g. Citizen of W	/hat Coun	
0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 XVidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify	k, White,	an Indian, etc. ite
50 p.m.	d within 72 h giene. er than "natu , the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 8th	s Education grade completed) College (1-4or 5+)	— ·	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired 11er	eation during most of work d)	king	Free Produ	Sta	te
007 9:5	uld be file Aental Hy rked othe tic event	To Be (	17. Father's Name (First, Middle, L Henry G. Ho	,			18. Mother's Nam	e (First, Middle, Burnne		e)	
	and 2 sho alth and 1 27 is ma er trauma		19a. Informant's Name/Relationshi		I .	Mailing Address (Street & 467 Berks				. ,	,
JLY 24, 2 Baltimore,	Pages 1 annument of He		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.	o El tellioval ilotti otate	20b. Place of I cemetery Bayvi	Disposition (Name of crematory or other place ew Cremat	ory 7/2	Date 5 / 0 7	20c. Location - Baltin	-	
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2,09289	tificate be executed  Examiner  By Agricultural as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Cue to (or as a co	onsequence of	):					
O. Box	death cer e attendin d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	1		23d. Date Mor	e of delive	ry Day Year
DANESTE	requires that the een signed by th nould be detache	þ	Part II. Other significant condition	s contributing to death but no	ot resulting in t	he underlying cause give	en in Part I.				e cause of death?
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BEULAH Division or Vital F	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga 2 Accident 3 Suicide 6 Could no determin	28a. Date of Injury (Month, Day Ye.	At home, farn	me of 28c. Injury	4 LI Nursing Ho	ome 5 ☐ Resid 28d. Describe h	ence 6 Nother	ed	
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one)  1X Certifying 2 Medical E	Physician: To the best of my xaminer: On the basis of examiner stated.	amination and	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and mai	nner as st	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	)		29c. License	e number 4372J		29d. Date signed	(Month, 1	Day, Year)
	5		30. Name and address of person w	OOD 2300 DUL	ANEY VA	ype, Print)	rimonium,		93	/	
	。 Sta Registr		31 Date filed (Month, Day, Year)	2007 3 Registrar's S	Signature	perte		.m 210.	<i>,</i> <u>J</u>		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Lindsey Dells, Sr. 3:54 ™ JULY 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 1, 1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours **XX**M 2□ F 213-26-9256 76 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Maryland 1 XXes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 Union Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? ► MAYes 2 □ No If Yes, Give 1951–54 Year or Dates Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician Electronic repairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Edward Dells Ethel Blanche Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland Sandra L. Dells Wife 1018 Union Avenue 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 7/30/07 Fullerton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland Signatur Baltimore, Maryland 21211 23a. Rart1. Enter the diseas shock, or heart failule ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 10 days disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the death certificate be executed burial-transit P.O. Box 68760 attending physician for use as the buria the detached ò signed to Division or Vital Records, page 2 should peen certificate has Physician: funeral director, After this or Attending death. the 1

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

The marked other than "instural", or Items 23a or impropriate it file maz'l is amsked other than "instural", or other traumatte event, the Medical Examiner must be rany injury or other traumatte event, the Medical Examiner must be rany injury or other traumatte event, the Medical Examiner must be rany injury or other traumatte event, the Medical Examiner must be rany in the medical Examiner must be rank to t

Physician

/Medicai **Examiner** 

Examiner

Physician/Medical

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Completed

Be

5

Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RIOR

32. Registrar's Signature

Ger

6

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

within 24 hours after death To the Funeral Director: filled in by Hospital

To the

State Registrar

m.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AT2438946

Union Memorial

29d. Date signed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene

		1 = For State Registrar		ertificate of Death	Re	g. No.	20300
Physi	ician	1. Decedent's Name (First, Middle, Last)	7	Juckworth	2. Date of Death Month	Day Year	3. Time of Death
	dical	Elmer  4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death	July	22 200 4c. County of Deat	
Exam	imer	Johns Hopkins	· ·			N/A	
Funera	al	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		8. Date of Birth (Month, Day,	9 Rint	hplace (State or Foreign untry)
Directo	or	220-68-1155	<sup>1 2   F  </sup> 49 Yrs.	World Days Flours Will.	Nov. 9,		t Virginia
and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
Maryl f sho	ρ	Maryland Baltin	2070	Middle River			1 ⊟Yes <b>≵(∑t</b> No
n the	Directo	Maryland   Baltin   10e. Street and Number	IOI E	10f. Zip Code	10	g. Citizen of What Co	untry?
th wit 23a o 1st be		3614 Dahlia Lane		2122	0	United St	ates
r dea	Funeral	TT: Walta States	. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecity Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
IryIand Z1Z15-UU36 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matte event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ∏Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	
Z I Z I S-UUSO d within 72 hours af giene. er than "natural", or the Me-fical Exami	ed	15. Decedent's Educa	tion 16a. Dec	edent's Usual Occupation	1	6b. Kind of Business/	White
hin 72	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) (Giv College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	king		
d with	ĕ	12 Years		te Salesman		H& S Bak	ery
be file tal Hy doth	å	17. Father's Name (First, Middle, Last)	_		ne (First, Middle, M		
aryland should be tand Mental Is marked or	ပ	Joseph B. Duckwort			V. McCour		
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		19a. Informant's Name/Relationship (Type Mary V. Duckworth		ing Address (Street and Number or Ru 4 Bessemer Ave.	ral Houte Number, Dundalk,	-	Zip Code) 21222
		20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date 2	20c. Location - City or	Town, State
baltimore, bermit. Pages 1 al Department of Hee mportant: If Item any Injury or othe		1 Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	ematory or other place) n Cemetery 7/2	5/2007	Baltimore,	Marvland
baltimo permit. Page Department o Important: If any Injury or	g	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Duda-Ruck Funeral			
a mage	Š .	Jenter a	mer	7922 Wise Ave. D	undalk. M	arvland 21	
		23a Part1. Enter the disease, or complication shock, or heart failure. List only one	tions that caused the death. Do not en cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physicia	_	Immediate Cause (Final disease or condition	Leukemic	Blast Crisis			Onset and Death
/Medica Examine	-	resulting in death)	Due to (or as a consequence of):				10 months
	ja Ja	Sequentially list conditions, b.	Due to (or as a consequence of).	rative Disor	der		וט וחטחדיוט
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	, ,				
U, exec an an		resulting in death) Last	Due to (or as a consequence of):				
ecords, P.O. BOX b8/bu, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medical	d.					
ertifica ling pl	Med	IF FEMALE:					_
BOX leath cer attendin for use	Physician/	in the past 12 months?		□Ectopic pregnancy		23d. Date of del Month	ivery Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 5 9□Unknown	Other (specify)			
uires that the de signed by the a		Part II. Other significant conditions contr	ibuting to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
quires quires in sign	ed by				1 ☐ Ye	s 2 No 3 Pr	obably 4 Munknown
law requires t as been signe should be c	Completed				24a. Was an		topsy findings available
The teh	E				autopsy perform 1□ Yes 2	ied? death?	completion of cause of 2 ☐ No
VICAL siclan: certifical rector, p	Be	25. Was case referred to medical examiner?			th (Check only one		
Or VILA Physiclan: r this certific ral director,	10	1 ☐ Yes 2 No	spital: 1 Impatient 2 ER/Outpatie		lome 5 ☐ Resider	nce 6 Other (Spec	cify)
	ü.	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	w injury occurred	
deatl ctor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At home, farm, s	M 1 Yes 2 No	28f Location (Str	eet and Number or Ru	umi Routo Numbor
	ertif	4 ☐ Homicide determined	building, etc. (Specify)	acod, ractory, office	City or Town,	State)	irai noute ivamber,
splta hours neral		29a. Certifier 1 ★ Certifying Physic	cian: To the best of my knowledge, dea	th occurred at the time, date and place	e, and due to the ca	use(s) and manner as	stated.
To the Hospital of within 24 hours aff To the Funeral D completely filled in	Medical	(Check only 2 Medical Examine one)	r: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occu	irred at the time, da	ite and place, and due	to the cause(s)
vithi To t	Ž	29b. Signature and title of certifier	1 m. 13-0 4	29c. License number		d. Date signed (Mont	h, Day, Year)
179		Anjoul sha			) [	Suly 22,	2007
10		30. Name and address of person who com Aniail Starrief	pleted cluster of death (Item 23a) (Type	, Print)	Rall's	ware with	71274
	State	31. Date filed (Month, Par, Yea) & 7	32. Rigistrar's Signature	castern moenue	SOUTH	nore, IND	21224
	state.	JUL 2 0 20	U/ Blow ho	1 0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amed item 20b per fh 8869 7-26-07 vt

			1 - For State Registrar	State of	Maryland?		artment of rtificate of		d Mental Hy	giene Reg. No.	-	21155)
	Physici /Medic		Decedent's Name (First, Middle	•	alie	11	Decker		2. Date of De Month July	Day	Year	3. Time of Death A 6445 M
100	Examir		4a. Facility Name (If not institution	-			4b. City, Town	, or Location of De	eath	4c. Count	y of Death	
			Johns Hopkins				Ba.]	timore (			T	/A
B	Funeral Director		5. Social Security Number 232-62-0464	6. Sex 7 1 □ M 212 F	7. Age (In yrs. last i	Yrs.	Months Day		lin. 8. Date of Bir (Month, Da April	th 19, Year) 6, 1938	Cour	place (State or Foreign htry) st Virginia
	and		Usual Residence of Decedent  10a, State 10b. County		10c. City, To	wn or Lo	cation					Od. Inside City Limits
	r 28a-f ahow	tor	Maryland	Baltimore				Dur	ndalk			1 ☐ Yes 21 No
	ith the	Director	10e. Street and Number	Datemore			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a c	aiD	3801 Old Nort	h Point Ro	ad		21	222		Unit	ed St	ates
36	after des or Itams	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	ried Armed Ford	2 <b>\%</b> No		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☐XN		(Specify Yes or No erto Rican, etc.)	14. Ra Bla Speci	ce - Americack, White,	
9	72 hours 'natural', dical Exe		15. Deceden	t's Education		a. Dece	dent's Usual Occ	upation		16b. Kind of E		
21215-0036	C	Completed		st grade completed)  College (1-		(Give life.	kind of work don DO NOT use reti Omemaker	e during most of v red)	working	Own		330tt y
	e filed within I Hygiene. other then	co .	17. Father's Name (First, Middle,	Last)		**			lame (First, Middle			
Maryland	s 1 and 2 should be filed f Health and Mental Hyg itam 27 Ia markad otha othar traumatic avant,	To B	Pete LePock						ldred Bec			
lar	2 sho and I la ma		19a. Informant's Name/Relations							er, City or Town	, State, Zip	Code)
	1 and dealth am 27 thar to		Mr. James M.	Decker, Sr			sition (Name of	orth Poir	Deta D	undalk,		21222
more,	permit. Pages 1 and 2 Department of Health s Important: If itam 27 It any injury or othar tra		1 XBurial 2 Cremation  1 Donation 5 □ Other 6		tate) cemei	tery, crer	on Cemet	.	<b>2007</b> 23 <del>/ 2006</del>	20c. Location Centre		
•	permit. Departi Import any inj		21. Signaturi Foneral Serice	OVIPA		79	922 Wise	Ave. D	l Home of undalk, M	Maryland	k, In 1 2122	c. 22
4	Physician		23a Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that call only one cause on each	ch line.	o not ent	er the mode of dy	ying, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. Due to (o	r as a consequence	e of):	Lacti	NVE.				3 wks
	p	iner	Se uential list conditions if any, leading to immediate cause. Enter Underlying		r as a consequenc		dep	letio				7
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last		ere Li		iascu	lav	۵۰۰۰۰	dend		2 9 = 5
O. Box	The law requires that the death certifica ate has been signed by the attending phypage 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown	1 Live bir	ome of pregnancy th 2  Fetal dea nt at time of death vn		Ectopic pregnan Other (specify)	су			ate of delive	ory Day Year
<u>α</u>	uires that signed b Id be deta	d by Pi	Part II. Other significant condition	ons contributing to dea		in the u	nderlying cause g	iven in Part I.		obacco use con	tribute to th	ably 4 Unknown
COL	w req	iete		٠	)				24a. Was	an 24b.	Were auto	psy findings available
of Vital Records,	n: The la icate has r, page 2								autor perfo 1 ☐ Yes	osy rmed? 2DXNo	prior to cor death?	npletion of cause of
Κ	Phyaician: this certificatal director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Haenital:	patient 2 ER/0	Outnation	t 3 DOA		eath <i>(Check only c</i> Home 5 Resid		(0:6	
on of	nding Phyaician: The lav th. : After this certificate has s funeral director, page 2		27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	28a. Date of (Month,		Time of Injury	28c. Inj			now injury occur		0
Division	To the Hospital or Attanding F within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer.	Certification:	3 Suicide 6 Could determ	ined   286. Place o	f Injury - At home, g, etc. (Specify)	farm, stre	eet, factory, office	9	28f. Location (S City or Tox	Street and Num. vn, State)	ber or Rura	l Route Number,
	e Hospit 24 hours te Funara	Medical (	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ig Physician: To the b Examiner: On the bas and manne	is of examination a	ge, death and/or inv	occurred at the restigation, in my	time, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
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	,0		M. no	holore	in	0	V	4575	7	July	20	0,2007
	5		30. Name and address of person	MCNGI	- seg	(Type,	Print)  YS 8	ookr	1 De	Be	lt.	MD 2(22)
	Sta Registr	_	31. Date filed (Month, Day, Year)	2007 32/Reg	gistrar's Signature	-1	-0-					

			1 _ State	State of Marylan			of Health of Death						1000
		y T	Registrar  1. Decedent's Name (First, Middle, Last)			Timeate	. Or Doan		2. Date of De				me of Death
Ы	Physicia /Medic		Larry		enn)	nar	K	ð	Month	21_1	200 a	1 09	906 AM
1	Examin		4a. Facility Name (If not institution, give str	reet and number)	. /	4b. City, T	own, or Location	/ .	11.	40	. County of Dea		
			5. Social Security Number Sex	7. Age (In yrs.	a (	) If Under 1	ALT MO	r 24 Hrs.   8	B. Date of Birt	th.	N/A		tate or Foreign
4	Funeral Director		052-34-1754	7. Age/(In yrs. 63	Yrs.		Days Hours	Min	(Month, Da )4/12/	v. Year.	)   Co	NY	
	D		Usual Residence of Decedent		. Town and	- notion			,,				ide City Limits
	arylar show	٦c	10a, State 10b, County  MD BALTIM		y, Town or Lo WINGS								Yes 2 No
	the M 28a-f notifie	Director	10e. Street and Number	OKL 0	WINGS	10f. Zip C	Code			10g. Ci	tizen of What Co	ountry?	
	n with	iO le	40 KINGSLEY ROAD				21117				USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 12  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1	.S. 13.	Was Decede If Yes, specif	ent of Hispanic O fy Cuban, Mexica No Specify		fy Yes or No ican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: WHITE			an,
2-00	72 hou 'natura di al Es	eted	15. Decedent's Educa (Specify only highest grade of	ation	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry			
21215-0036	d within giene. er than ' the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		INER					RESTAU	RANT	
Maryland	ild be file lental Hy ked oth	To Be (	17. Father's Name ( <i>First, Middle, Last</i> ) DONALD		BERNST	EIN	ı	her's Name ( OTHY	First, Middle,	Maider	,	DENM/	4RK
ary	should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type			•	Street and Num						
∑ ″	f and 2 Health lem 27		LORRAINE DENMARK /			(INGSLE osition (Name	Y ROAD,	OWING Da			MD 211 ocation - City or		ate
Baltimore,	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1	moval from State	WETERY	EFTORE	ner place)	07/24/	2007	PIN	IELAWN,	NY	
Balti	permit. Departn Imports any Inju		21. Signature of Funeral Service Licensee		2		Address of Faci	ility SOL	LEVII	NSON	I & BROS	., II	VC. 21208
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	/Medical Examiner		resulting in death)	Due to (or as a conseq		ailu.	0					フぃ	ears
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Вох	the Hospital or Attending Physician: The law requires that the death certific hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending propletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 ☐ Ectopic pregnancy					23d. Date of delivery Month Day		livery Day	Year
P.O.	that the sd by the detach	Phy	Part II. Other significant conditions contri	ributing to death but not res	ulting in the u	underlying ca	use given in Parl	tl.	23e. Did 1	obacco	use contribute t	o the cau	se of death?
Records,	quires n signe ald be	d by							1 🗆	Yes 2	2□ No 3□ F	robably	4 Unknown
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Ä	<b>sician</b> : The law certificate has t irector, page 2 s	Com							perfo	rmed? 2 □ N	death?	1	
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0	ding Physician: The n. After this certificate ha funeral director, page	<u>۲</u>	1 ☐ Yes 2 No Ho 27. Manner of Death	28a. Date of Injury	ER/Outpatie		Bc. Injury at Work?		e 5 ☐ Resi 3d. Describe		6 ☐Other (Sparry occurred	ecify)	
on	nding Ph tth. r: After th e funeral	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 [	□No					
Division or Vital	or Attencifier death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special		treet, factory,	office	28	f. Location ( City or To		nd Number or F te)	Tural Rout	e Number,
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical Examine	cian: To the best of my kno er: On the basis of examina	owledge, dea ation and/or i	ith occurred a nvestigation,	at the time, date in my opinion, d	l and place, ar eath occurre	nd due to the d at the time	cause( date a	s) and manner and place, and du	s stated. le to the c	ause(s)
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-	1		30. Name and address of person who com			, Print)	100		1		7 0 1	/	, MD 228
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